

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 48382**
Registered No. **16**

1. PLACE OF DEATH

County of **Ada**City of **Boise**Registration District No. **2**Primary Registration District No. **1004**(No. **St Lukes Hospital** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Cain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 16 - 1925
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many ____ hrs.
or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Elbert Cain.

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky.

12. MAIDEN NAME OF MOTHER

Addie Murray

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Elbert Cain

15.

Filed **Jan 17 1925**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 16 - 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 16 1925 to **Jan 16 1925**
that I last saw him alive on **Jan 16 1925**
and that death occurred on the date stated above, at **10** M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

1/17/25

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem

DATE OF BURIAL

Jan 17 1925

20. UNDERTAKER

Summers & Spade

ADDRESS

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Am

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

MAR 3 1925

BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

Primary Registration District No. *8*(No. *Morris Creek, Call Star* St.)State File No. *S 48631*Local Registrar's No. *7*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Lusen Louise Kinzey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

*W.*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word)

6. DATE OF BIRTH

Jan. 29 - 1925

(Month)

(Day)

(Year)

7. ~~AGE~~*Still Born*

Yrs.

Mos.

ds.

IF LESS than 1
day how many
hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*None*

9. BIRTHPLACE

(State or Country)

*Idaho*10. NAME OF
Father*J. B. Kinzey*11. BIRTHPLACE
OF FATHER

(State or Country)

*Idaho*12. MAIDEN NAME
OF MOTHER*Gertrude Gehman*13. BIRTHPLACE
OF MOTHER

(State or Country)

Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Phil S. Gehman

(Address)

Barber

15.

Filed

Feb. 28

1925

R. H. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 29th 1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

10 to *10*
that I last saw him alive on *10*
and that death occurred on the date stated above *10*

The CAUSE OF DEATH* was as follows:

Still Born

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary) *X*

(Duration)

yrs.

mos.

ds.

(Signed)

W. M. Braken

1/31 1925

(Address)

Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Highland Cemetery

DATE OF BURIAL

2/1/25 19

20. UNDERTAKER

W. M. Braken

ADDRESS

*Boise**Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Haines

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word)

6. DATE OF BIRTH

January 29 1925
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country) *Pocatello Idaho*10. NAME OF
Father*P. M. Haines*11. BIRTHPLACE
OF FATHER(State or Country) *Nebraska*12. MAIDEN NAME
OF MOTHER*Alvetha Jensen*13. BIRTHPLACE
OF MOTHER(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. M. Haines

(Address)

Pocatello

15.

Filed

*1-30 1925**J. J. Haines*
Local Registrar

CERTIFICATE OF DEATH

Registration District No. *28*Registration District No. *2161*(No. *St. Anthony Hospital*)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF STATISTICS

State File No.

Local Registrar's No. *4527*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 29 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan 29 1925 to Jan 29 1925*that I last saw him alive on *Jan 29 1925*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory (Secondary) *Congenital anomalies*

(Duration) yrs. mos. ds.

(Signed) *W. W. Brothers M. D.**1-29-25* (Address) *Pocatello Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

West View

DATE OF BURIAL

1-31 1925

20. UNDERTAKER

Schumaker & Hall

ADDRESS

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PRECEDING the state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

APR 5 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 48930**

1. PLACE OF DEATH

County of *Adams*
City of *Mesa*

Registration District No. (No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Baby Hurston*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH

March 28 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. *no*
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Adams Co Idaho*

10. NAME OF FATHER

Van Hurston

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mamma Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lee Howard*

(Address) *Mesa Idaho*

15. *3-21* 19 *25* *Wm Brown*
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 28 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19.... to 19....
that I last saw h..... alive on 19....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. M. Brown* M. D.

19.... (Address) *Council Bluffs Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.... yrs. mos. days. In the State.... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cotton Wood cemetery Mesa 29 1925

20. UNDERTAKER

ADDRESS

W. M. Brown

Council Bluffs Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon
City of ampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Brown

RECEIVED CERTIFICATE OF DEATH

APR 5 1925
BUREAU OF VITAL STATISTICS
Registration District No. 1006
(St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 8 43000

Local Registrar's No. 91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

March 27 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Apr 4 1925
Mac Farby
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Still born
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Signed) Thos E. Mangum, D.
3-27-1925 (Address) Idaho, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
3-29 1925

20. UNDERTAKER

ADDRESS
Wilder Co
E. V. Beckham Caldwell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of**(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

Am

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH APR 16 1925
County of Bennett Registration District No. 2141
City of Beaumont Primary Registration District No. 2141
If death occurs away from usual residence, give facts called for under special information. (No. 2141)
2. FULL NAME Infant Grafton

State File No. 49110
Local Registrar's No. 4563
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX M
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)
6. DATE OF BIRTH Mar 4 1925
(Month) (Day) (Year)
7. AGE Still Born
IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Joseph Grafton

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Glady's Jackson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. R. J. Jackson
(Address) Beaumont, Ida

15. Filed 3/6 1925
Local Registrar W. H. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19, that I last saw him alive on 19, and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Premature birth
Still born
(Duration) yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.
(Signed) J. J. R. of M. D.
4/6 1925 (Address) Beaumont, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days, State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View DATE OF BURIAL Mar 4 1925

20. UNDERTAKER Chambers ADDRESS Beaumont, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

1. PLACE OF DEATH

County of *Bone*City of *Horse Shoe Bend*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

APR 21 1925

STATISTICS

CERTIFICATE OF DEATH

District No.

County District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *S 49179*
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

*March**29**1925*

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Horse Shoe Bend

10. NAME OF FATHER

Henry Claus

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Mary Reed

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*April 12 1925**Mrs E S Rogien*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*March**29**1925*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Still born. premature birth
Elle Mann Lundberg

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Mrs E S Rogien M. D.*Apr 15 1925*(Address) *Local Registrar*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Horse Shoe Bend**March 29 1925*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MB

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 6 20M.1-16-12

1. PLACE OF DEATH.

County of *Lewis*

City of *Kamiah*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
APR 11 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration No. *49*

Sanitation District No. *2428*

(No. *(Shelton)* St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *S49295*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *Ind* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH

Mich 16 1915
(Month) (Day) (Year)

7. AGE

Shelton
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Johnathan Frank

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elle Frank

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Johnathan Frank
Kamiah Ida

(Address)

15.

Filed

3/18

1925

Johnathan Frank
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 16 1925 to *March 16 1925*

that I last saw him alive on *March 16 1925*

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Shelton

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. B. Bryan* M. D.

3/17/25 (Address) *Kamiah Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ind Cem No 1

DATE OF BURIAL

3/18 1925

20. UNDERTAKER

W. B. Bryan

ADDRESS

Kamiah Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MB

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME (Not named) Baby Moore

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. S 49513
Local Registrar's No. 114
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUN 6 1925
BUREAU OF VITAL STATISTICS
REGISTERED DISTRICT NO. 7
REGISTRATION DISTRICT NO. 1906
(No. Murray Block St.)

PERSONAL AND STATISTICAL PARTICULARS	
3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u> (Write the word)
5. SINGLE, MARRIED, WIDOWED OR DIVORCED	
6. DATE OF BIRTH <u>April 22 1925</u> (Month) (Day) (Year)	
7. AGE <u>6</u> Yrs. <u>2</u> Mos. <u>2</u> ds.	IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION (a) Trade, profession or particular kind of work. (b) General nature of industry, business or establishment in which employed (or employer).	
9. BIRTHPLACE (State or Country) <u>Idaho</u>	
10. NAME OF FATHER <u>Will C. Moore</u>	
11. BIRTHPLACE OF FATHER (State or Country) <u>Wash.</u>	
12. MAIDEN NAME OF MOTHER <u>Larry Lyons</u>	
13. BIRTHPLACE OF MOTHER (State or Country) <u>Canada</u>	
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Will C. Moore</u> (Address) <u>Rt 4 #5 Nampa</u>	
15. Filed <u>June 6</u> 19 <u>25</u> <u>Max Ferby</u> Local Registrar	

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH <u>5</u> <u>22</u> <u>1925</u> (Month) (Day) (Year)	
17. I HEREBY CERTIFY, That I attended deceased from <u>19</u> to <u>at birth</u> <u>19</u> , that I last saw him alive on <u>19</u> , and that death occurred on the date stated above, at <u>M.</u>	
The CAUSE OF DEATH* was as follows: <u>Dead born -</u> <u>Cerebral section -</u> <u>mother in convulsion</u> <u>of nephritic origin</u> (Duration) yrs. mos. ds. Contributory <u>nephritic in mother</u> (Secondary) (Duration) yrs. mos. ds. (Signed) <u>J. H. Murray</u> M. D. <u>5/12/25</u> (Address) <u>Nampa, Idaho</u>	
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place In the of death yrs. mos. days. State yrs. mos. ds. Where was disease contracted if not at place of death? Former or usual residence	
19. PLACE OF BURIAL OR REMOVAL <u>Archieburn</u>	DATE OF BURIAL <u>5/23 1925</u>
20. UNDERTAKER <u>A. H. Robinson</u>	ADDRESS <u>Nampa</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and, therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

102

1. PLACE OF DEATH

County of *Spokane*City of *Spokane*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

JUN 4 1925

BUREAU OF VITAL STATISTICS

Registration District No.

Registration District No. 1085

(No. *1085*)(City of *Spokane* St.)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

49747

Registered No.

1354

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

(Write the word.)

6. DATE OF BIRTH

May 9 1925

(Month)

(Day)

(Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Infant*

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*10. NAME OF FATHER *Ired Munnally*

11. BIRTHPLACE OF FATHER

(State or Country) *New Mexico*12. MAIDEN NAME OF MOTHER *Mez Waite*

13. BIRTHPLACE OF MOTHER

(State or Country) *Wis*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ired Munnally*(Address) *Contact, Jr.*

15. June 1-25

Filed

19

Local Registrar *John F. Cooper*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9 1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*277/2 1922 to 277/2 1925*that I last saw *alive* on *19*and that death occurred on the date stated above, at *11:30* P.M.

The CAUSE OF DEATH was as follows:

Stillborn Cause of death unknown

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. G. F.* M. D.*5/11/1925* (Address) *Spokane Falls, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Spokane Falls**May 11, 1925*

20. UNDERTAKER

ADDRESS

*Spokane Falls**Spokane Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MB

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Tocchi

RECEIVED
JUN 12 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
(No.) (St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. S 49771
Local Registrar's No. 4618

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

6. DATE OF BIRTH

May 24 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Simone Tocchi

11. BIRTHPLACE OF FATHER

(State or Country) Austria

12. MAIDEN NAME OF MOTHER

Josephine Sesseli

13. BIRTHPLACE OF MOTHER

(State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Simon Tocchi
(Address) Pocatello, Ida.

15.

Filed May 24 1925

W. H. Hamblin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 24 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1925 to May 25 1925

that I last saw her alive on April 25 1925, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) Still Born

(Duration) — yrs. — mos. — ds.

(Signed) Dr. J. M. D.

5/25 1925 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — days. State — yrs. — mos. — ds.
Where was disease contracted
if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pocatello, Ida.

DATE OF BURIAL

5-24 1925

20. UNDERTAKER

W. H. Hamblin & Co.

ADDRESS

Pocatello, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

119

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father

11. BIRTHPLACE

OF FATHER

(State or Country)

12. MAIDEN NAME

OF MOTHER

13. BIRTHPLACE

OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
that I last saw h..... alive on.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs..... mos..... days. State..... yrs..... mos..... ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Madison*

City of *Bozeman*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Register District No. *100*

Registration District No. *2178*

BUREAU OF VITAL STATISTICS

Rigby

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *S 49795*

Local Registrar's No. *220*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Shel Born*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

May

26

1925

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day how many

hrs. or

min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Baller

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Perley

10. NAME OF

Father

Joe Reyes

11. BIRTHPLACE

OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME

OF MOTHER

Lope Martinez

13. BIRTHPLACE

OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mark Ryba

(Address)

Perley Box 165

15.

6/4

1925

W. G. Ryan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

26

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 24 1925 to May 26 1925

that I last saw him alive on *May 24* 19...

and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Chr. Nephritis in Mother

(Duration)

yrs.

mos.

ds.

(Signed)

H. B. Rigby

6-13-1925

(Address)

Perley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. days, State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Perley

DATE OF BURIAL

7/27 1925

20. UNDERTAKER

W. G. Ryan

ADDRESS

W. G. Ryan

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **50168**
Registered No. **10**

1. PLACE OF DEATH

County of **Leoneville** District No. **1016**
City of **Shoshone** Primary Registration District No. **1016** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
BUREAU OF VITAL STATISTICS
AUG 11 1925

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

male **white** (Write the word.)

6. DATE OF BIRTH

July 24 1925
(Month) (Day) (Year)

7. AGE

Still Born IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant)

(Address)

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 23 1925** to **June 24 1925** that I last saw him alive on **June 24 1925** and that death occurred on the date stated above, at **7 A.M.** The CAUSE OF DEATH* was as follows:
Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **W. H. Baugh** M. D.

1/24 1925 (Address) **Shoshone Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone **7-24-1925**

20. UNDERTAKER

ADDRESS

O. J. Minnow **Shoshone**

Victor Carrara

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1. PLACE OF DEATH

County of Banner
City of Facet

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant (Battles)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED

5. DATE OF BIRTH

6. AGE

IF LESS than 1 day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1925

Local Registrar

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from
6-10-1925 to 6-10-1925that I last saw him alive on 6-10-1925
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still born -
SyphiliticContributory
(Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Mountain View
June 11, 1925
Schumacher & CoRECEIVED
JUL 17 1925
BUREAU OF VITAL STATISTICS

28

2141

50202

4636

189

M. D.

6/10 1925

Facet

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

M. D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Hywae*

City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Grizzle

RECEIVED
AUG 4 1925
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
Register District No. *96*
Registration District No. *1009*
St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. *50325*
Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

Premature
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Lewiston, Ida*

10. NAME OF FATHER

Boyd Grizzle

11. BIRTHPLACE OF FATHER

(State or Country) *Penn*

12. MAIDEN NAME OF MOTHER

Bessie Mary

13. BIRTHPLACE OF MOTHER

(State or Country) *Iowa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *July 6* 1925 *Annan E. Bruce*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 *15* *1925*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature not alive

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *La Fayette Sumner* M. D.

19 (Address) *Lewiston, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Ida

DATE OF BURIAL

7/15 1925

20. UNDERTAKER

Wasson Undertaking Co

ADDRESS

Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

1. PLACE OF DEATH **Twin Falls** RECEIVED
 County of **Twin Falls** AUG 4 Registration District No. **37**
 City of **Twin Falls** Primary Registration District No. **1085**
 If death occurs away from usual residence, give facts called for under special information. **STAT (No. Co Gen. Hospital St.)**
 2. FULL NAME **Olliver Milton Cammack**

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

State File No. **S50349**
 Local Registrar's No. **1376**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

6. DATE OF BIRTH

July 28 1925
 (Month) (Day) (Year)

7. AGE

0 Yrs. **0** Mos. **0** ds.

IF LESS than 1 day how many
 hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

Earl Cammack

11. BIRTHPLACE

OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME

OF MOTHER

Myrtle Sturgeon

13. BIRTHPLACE

OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Earl Cammack**

(Address)

Filer Ida.

15.

Filed **8-1-25**

19

John H. [Signature]
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 _____ 19____ to _____ 19____,

that I last saw him alive on _____ 19____,
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born**Probable Cause; Toxic**

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. J. Morgan M. D.

7-29-1925 (Address) **Twin Falls Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
 of death _____ yrs. _____ mos. _____ days, State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls Ida.

DATE OF BURIAL

7-29-25

20. UNDERTAKER

P. J. Grossman

ADDRESS

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MARGIN RESERVE FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
AUG 31 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File # 50390

1. PLACE OF DEATH
County of Adams
City of Mesa
Registration District No.
Primary Registration District No.
(No.) St.

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Scouster

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

16. DATE OF DEATH Mar 28 19 25
(Month) (Day) (Year)

6. DATE OF BIRTH March 28 19 22
(Month) (Day) (Year)

7. AGE Sillborn IF LESS than 1 day how many..... hrs. or..... min.?
Yrs. Mos. ds.

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19..... and that death occurred on the date stated above, at..... M. The CAUSE OF DEATH* was as follows:

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Sillborn
(Duration) Yrs. mos. ds.

9. BIRTHPLACE Mesa
(State or Country)

Contributory (Secondary)
(Duration) yrs. mos. ds.

10. NAME OF FATHER Van Scouster

(Signed) M. M. Brown M. D.

11. BIRTHPLACE OF FATHER
(State or Country)

Mar 1 1925 (Address)

12. MAIDEN NAME OF MOTHER Minnie Miller

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER
(State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lee Howard

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

(Address) Mesa

Where was disease contracted if not at place of death?
Former or usual residence

15. Filed 3-31 19..... Local Registrar M. M. Brown

19. PLACE OF BURIAL OR REMOVAL Bottom Wood DATE OF BURIAL Mar 29 19 25

20. UNDERTAKER Squidman ADDRESS Cambridge

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BlaineCity of Hailey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Infant)Moedl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

8 20 1925
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. ds.IF LESS than 1 day
how many — hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Carl Moedl

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Miss Louisa Hawley

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Hailey, Idaho

15.

Filed 9-29 1925 K. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 20 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 8/20 1925 to 8/20 1925that I last saw him alive on 8/20 1925and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Still Born
Premature birth (6 1/2 mo)
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. J. ...8/20/25 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey

DATE OF BURIAL

Aug 20 1925

20. UNDERTAKER

Rd Harris by Elana Hailey

ADDRESS

Hailey

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M: 1-19.

1. PLACE OF DEATH

County of CassiaCity of P.O. Bridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest. Nelson

MEDICAL CERTIFICATE OF DEATH

Registration No. 119BUREAU OF VITAL STATISTICS
(No. 2197 St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. \$ 50710

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED

whitesingle

(Write the word)

5. DATE OF BIRTH

Sept 16 1925
(Month) (Day) (Year)

6. AGE

Stillborn

Yrs. Mos. ds.

IF LESS than 1 day how many
hrs. or min.?

7. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business or establishment in which employed (or employer)

8. BIRTHPLACE

(State or Country) Cassia Co. Idaho

9. NAME OF

Father

Frank Olson

10. BIRTHPLACE OF FATHER

(State or Country) Idaho

11. MAIDEN NAME

OF MOTHER

Mary Geneva Jolley

12. BIRTHPLACE

OF MOTHER

(State or Country) Utah

13. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X Frank Olson

(Address)

Bridge, Idaho

14. FILED

Sept 30 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH

Sept 16 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1925 to Sept 16 1925, that I last saw him stillborn on Sept 16 1925, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn - Compression of umbilical cord during birth of his twin

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Leona Frazier M. D.

19.

(Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Bridge, Idaho Cemetery

DATE OF BURIAL

Sept 17 1925

20. UNDERTAKER

Frank Olson

ADDRESS

Bridge

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Idaho*City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Stillborn**Duby*

CERTIFICATE OF DEATH

Residence District No. *96*City Registration District No. *1009*

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word.)

6. DATE OF BIRTH

Aug 31 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. M. Dudy

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Bess Savage

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. M. Dudy
Lewiston, Idaho

15.

Filed *Sept 8 1925* *Susan E Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 31 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 31 1925 to *Aug 31 1925*
that I last saw him alive on *Aug 31 1925*and that death occurred on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Stillborn
Premature birth(Duration) Yrs. *4 1/2* mos. *11* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. B. Braddock* M. D.*Aug 31 1925* (Address) *Lewiston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lewiston, Idaho**19*

20. UNDERTAKER

ADDRESS

*Brown-Alum Co.**Lewiston, Id*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Newham*
City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Feider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female white**Stillborn*
(Write the word)

6. DATE OF BIRTH

Stillborn 9/15 1925
(Month) (Day) (Year)

7. AGE

*Stillborn*IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
Father*F. A. Feider*11. BIRTHPLACE
OF FATHER

(State or Country)

*Washington*12. MAIDEN NAME
OF MOTHER*Alene Adenew*13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. Feider

(Address)

Pomeroy Wash

15.

Filed

Oct-7

1925

Russ E. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

Sept 15th 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
*Sept 15th 1925 to Sept 18th 1925*that I last saw him alive on *19*,and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. E. Larsson M. D.

19

(Address) *Lewiston Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pomeroy Wash

19

20. UNDERTAKER

ADDRESS

*Russ E. Bruce**Lewiston*

2146

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

2146

1. PLACE OF DEATH

County of *Myrtle*City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

OCT 10 1925

BUREAU OF VITAL STATISTICS

Registration District No. *96*Registration District No. *1009*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFILE NO. *50833*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Sept 22 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*Infant*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. D. Schadt

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Murray

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Oct - 7 1925* *Susan E. Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 22 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 22 1925* to *Sept 22 1925* that I last saw him alive on *Sept 22 1925* and that death occurred on the date stated above, at *2 A.M.*

The CAUSE OF DEATH was as follows:

Stillborn
Polyhydramnios of mother
Premature delivery
(Duration) *6 mos gestation*Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. J. Broadbent* M. D.*Sept 22 1925* (Address) *Lewiston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Normal Hill

DATE OF BURIAL

Sept 22 1925

20. UNDERTAKER

Proctor - Warr Co

ADDRESS

Lewiston Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1. PLACE OF DEATH

County of *Nez Perce*City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
OCT 10 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *96*Primary Registration District No. *1009*

St.)

Registered No. _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *50834*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female *white*

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single *(Widow)*

6. DATE OF BIRTH

Sept 22nd 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. D. Schadt

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mary Murray

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*J. D. Schadt,
Moller, Idaho*

15.

Filed

Oct - 7 1925 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 22 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 22 1925* to *Sept 22 1925* that I last saw *her* alive on *Sept 22 1925* and that death occurred on the date stated above, at *2 A.M.*

The CAUSE OF DEATH* was as follows:

*Polyhydramnios of mother
Premature delivery
6 months gestation*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*E. G. Broadbent M. D.**Sept 22 1925* (Address) *Lewiston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho *Sept 22 1925*

20. UNDERTAKER

ADDRESS

Brown - Warr Co. Lewiston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MM

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

OCT 16 1925

Registration District No.

Statistical District No.

(No.

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

51151

Local Registrar's No.

246

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE & SINGLE, MARRIED, WID-
OWED OR DIVORCED

5. DATE OF BIRTH

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father

11. BIRTHPLACE

OF FATHER

(State or Country)

12. MAIDEN NAME

OF MOTHER

13. BIRTHPLACE

OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9

24

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
9 - 24 1925, to 9 - 24 - 1925,

that I last saw her alive on September 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature birth.
Foetus not viable.

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

9/25 1925

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

MM

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **51307**

PLACE OF DEATH

County of **Bannock** Registration District No. **28**

City of **Pocaters** Primary Registration District No. **214**

Local Registrar's No. **4685**

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Infant M. J. Guine**

(a) Residence. No. _____ St. _____

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 Single, Married, Widowed, or Divorced (write the word) **Infant**

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) **Oct 23-1925**

Age in Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) **Idaho**
(State or country)

10 NAME OF FATHER **A. L. M. J. Guine**

11 BIRTHPLACE OF FATHER (city or town) **Idaho**
(State or country)

12 MAIDEN NAME OF MOTHER **Meliah Baum**

13 BIRTHPLACE OF MOTHER (city or town) **Idaho**
(State or country)

14 Informant **G. H. M. J. Guine**
(Address) **Pocaters N. J. City**

15 Filed **10/24**, 19**25** **J. R. Guine**
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **October 23**, 19**25**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **10/22**, 19**25**, to **10/22**, 19**25**,
that I last saw her alive on **10/22**, 19**25**,
and that death occurred, on the date stated above, at **6:10 p** m.

The CAUSE OF DEATH* was as follows:

Still-born

CONTRIBUTORY (Secondary)

18 Where was disease contracted **No**
if not at place of death?

Did an operation precede death? **No** Date of _____

Was there an autopsy? **No**

What test confirmed diagnosis? **W. A. Wright**

(Signed) **W. A. Wright**, M. D.
10/24, 19**25** (Address) **Pocaters, Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal **Mountain View** Date of Burial **Oct 24**, 19**25**

20. Undertaker **Dohmacker & Co** Address **Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

113

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Barnett
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 1045

Primary Registration District No. 1045

Age 24

St Anthony's Hosp

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51634

Local Registrar's No. 470

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

6. DATE OF BIRTH

Nov 24 1925
(Month) (Day) (Year)

7. AGE

Stillborn IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Pac, Idaho

10. NAME OF FATHER

Lawrence Schults

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Bessie Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lawrence Schults
Pocatello Idaho

15.

Filed

Nov 24 1925

R Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 24 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1925 to Nov 24 1925.

that I last saw him alive on Nov 24 1925.

and that death occurred on the date stated above, at N.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory (Secondary)

Rupel glaucoma
9 months

(Duration) yrs. mos. ds.

(Signed)

W W Bickner M. D.

(Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem. Nov 25 1925

20. UNDERTAKER

ADDRESS

Mc Nam Undt Co Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, Foreman, Manager, Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, Anaemia**" (merely symptomatic), "**Atrophy, Collapse, Coma, Convulsions, Debility, Congenital, Senile, etc., Dropsy, Exhaustion, Heart Failure, Hemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-20 A. 1-19.

SOLICITORS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of **FR. MONT**
City of **ASHTON**

Registration District No. **102**
Primary Registration District No. **6**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BABY REYNOLDS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **S 51781**
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **FEMALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH **DEC. 16th 1925**
(Month) (Day) (Year)

7. AGE **IF LESS than 1 day**
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (for employer)

9. BIRTHPLACE

(State or Country) **ORA IDAHO**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER **BRUCE REYNOLDS**
(State or Country) **UTAH.**

12. MAIDEN NAME OF MOTHER

ZORA HARRIS

13. BIRTHPLACE OF MOTHER

(State or Country) **IDAHO**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **BRUCE REYNOLDS**
(Address) **ORA IDAHO**

15. Filled **12/16 1925** **Local Registrar**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec 16 1925**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 19** to **Dec 19**
that I last saw him alive on 19.....
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Stillborn

Contributory
(Secondary)

(Signed) **Dr. R. H. Kiser**

Dec 16 1925 (Address) **Ashton, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **ASHTON IDAHO** DATE OF BURIAL **12/16/25**
20. UNDERTAKER **LEWIS KISER** ADDRESS **ASHTON IDAHO**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 10 ds.*; *Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

NB

FORM V. S. No. 5-25 M. 1-19.

BOISE IDAHO CITY OF ASHTON COUNTY OF FREMONT

1. PLACE OF DEATH

County of **FREMONT**City of **ASHTON**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BABY REYNOLDSRegistration District No. **102**Primary Registration District No. **6**

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **S 51782**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FEMALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

DEC. 16/ 1925
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

ORA IDAHO

10. NAME OF FATHER

BRUCE REYNOLDS

11. BIRTHPLACE OF FATHER

(State or Country)

UTAH

12. MAIDEN NAME OF MOTHER

ZORA**HARRIS****REYNOLDS**

13. BIRTHPLACE OF MOTHER

(State or Country)

IDAHO**JOHN X**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

BRUCE REYNOLDS

(Address)

ORA IDAHO.

15.

Filed

12/16

19

25**Local Registrar**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 16 25
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born!

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 20 ds.*; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WW

1. PLACE OF DEATH

County of LatahCity of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Buchanan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Child
(Write the word.)

6. DATE OF BIRTH

Dec. 21 1925
(Month) (Day) (Year)

7. AGE

Stillbirth

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Child

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W.N. Buchanan

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Edna Spray

13. BIRTHPLACE OF MOTHER

(State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.N. Buchanan(Address) Moscow, Idaho

15.

Filed 12/22 1925

Local Registrar

RECEIVED
JAN 9
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
Registration District No. 101
Primary Registration District No. 1011
St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 51837
Registered No. 76

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 21 1925 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 21 1925, to Dec 21 1925that I last saw him alive on Dec 21 1925and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Perinatal birth
cause unknown
Duration of intra uterine
gestation 4 months mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. J. Armstrong M. D.12/22 1925 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

20. UNDERTAKER

None

DATE OF BURIAL

12/22 1925

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-1-1918

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

8. OCCUPATION

9. BIRTHPLACE

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

15.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from that I last saw her alive on and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

19. PLACE OF BURIAL OR REMOVAL

20. UNDERTAKER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1896

28

2161

(No. 1)

Estyle Hagan

Female white

Single

Dec 4 1925

Still born

None

Pocatello, Ida.

Ernest Hagan

Missouri

Hattie Mesghers

Oklahoma

Ernest Hagan

Pocatello, Idaho

Dec 7 1925

Local Registrar

Dec 4 1925

Malposition requiring section & instrumental delivery & transverse mother had repeating malposition

Malposition

O. W. Lynn M. D.

Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

At place of death

Where was disease contracted if not at place of death?

Former or usual residence

Pocatello, Idaho

Pocatello, Idaho

Dec 7 1925

McDonnell

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson,
City of Rigby.

Registration District No. 98
Primary Registration District No. 2176
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Haywood.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. S 52864
Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH July 7th 1925
(Month) (Day) (Year)

7. AGE Still Born
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Babe

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo. C. Haywood

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Laura M. Scott

13. BIRTHPLACE OF MOTHER

(State or Country)

Mesa Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. C. Haywood
(Address) Rigby Idaho

15. Apr 10. 26 Pray H. Fisher
Filed 19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 7th 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

not syphilis
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Difficult and prolonged labor; very large child.
(Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. G. Anderson M. D.
19 _____ (Address) Rigby - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rigby, Ida. 7/8 1925

20. UNDERTAKER

ADDRESS

Ira J. Taylor Rigby, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill*; (a) *Salesman, (b) Grocery*; (a) *Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Mch 10 1926

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1925 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH Idaho STATE OF IDAHO
FEB 7 1925 DEPARTMENT OF PUBLIC WELFARE
COUNTY OF Dingham BUREAU OF VITAL STATISTICS
CITY OF Blackfoot BUREAU OF VITAL STATISTICS
No. 6 Curtis St St. Registration District No. 121 State File No. 128719
Hospital 559 109 006 337 Primary Registration District No. 1007 Local Registrar's No. 19
FULL NAME OF CHILD Harold David Neider
(Certificate of no value without full name of child)

Sex of Child Male Twin ✓ Triple ✓ or other? ✓ and { Number in order of birth 1 } Legitimate? Yes Date of birth Jan 9 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME Charles D. Neider
RESIDENCE Blackfoot
COLOR White AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Idaho
OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Annie Marie Leach
RESIDENCE Blackfoot
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Illinois
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Resuscitative Stillborn at 3:45 9 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. W. Beck

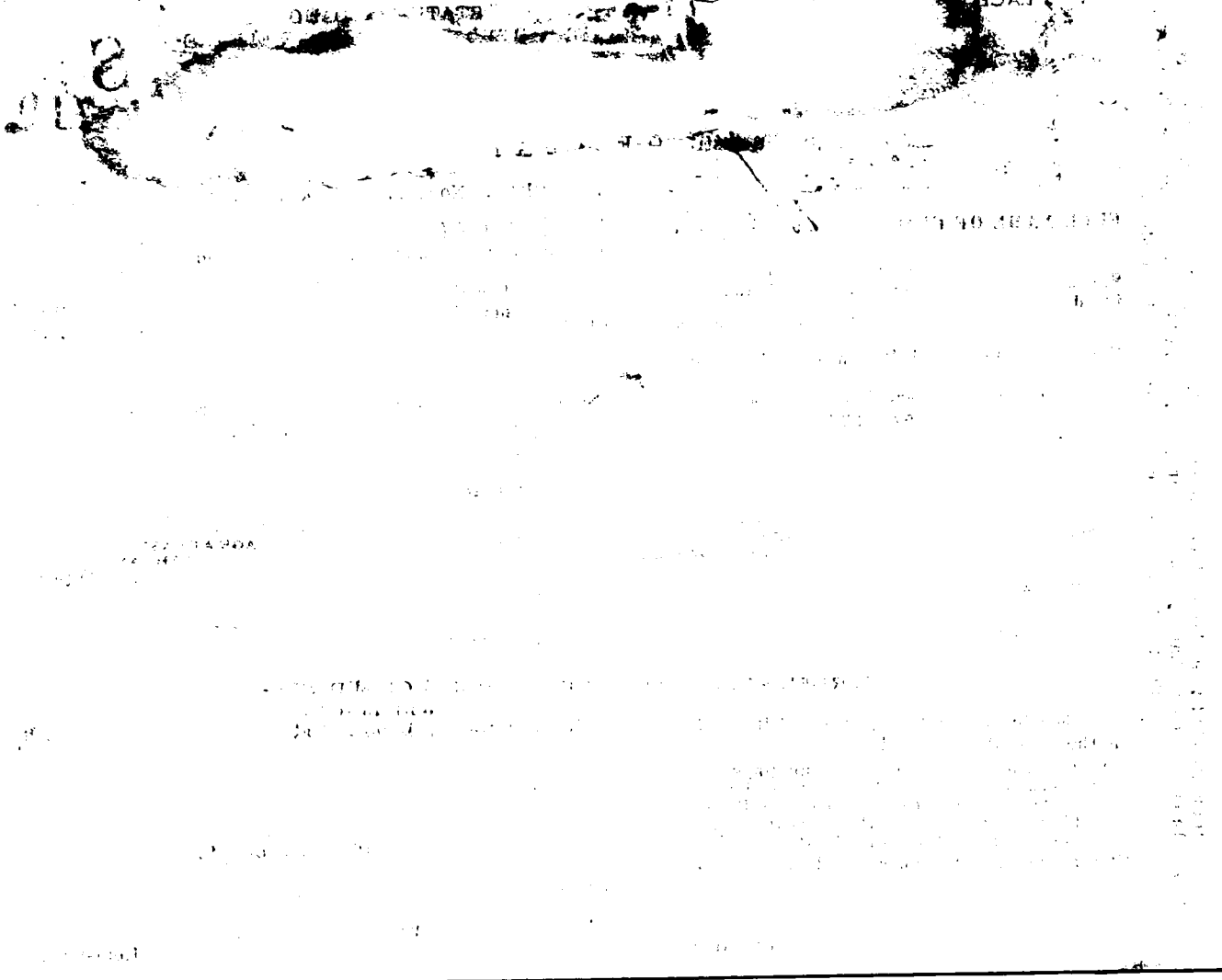
(Physician or midwife)

Address Blackfoot

Filed Feb 4 1925

Registrar.

Registrar.



Boise, Idaho FEB 13 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * *

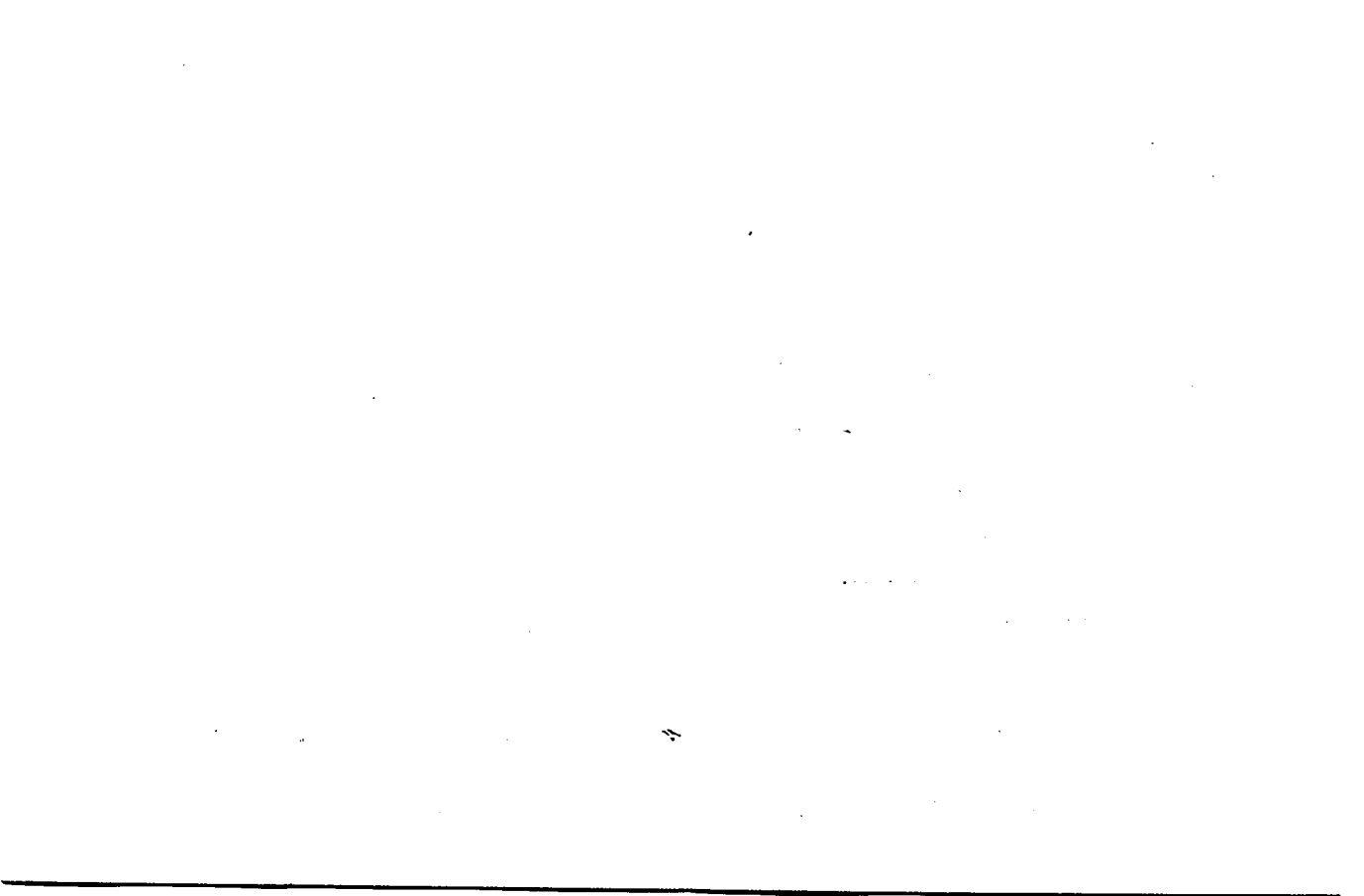
Place { CITY Blackfoot FILE NO. 128719
 of { ST. Idaho DATE OF BIRTH _____
 Birth { COUNTY Bingham SEX OF CHILD Male
 FATHER Charles D. Miller MOTHER Clara Mae Leach
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Harold David MillerCharles D. Miller

Signature of Father or Mother.

RECEIVED
 FEB 23 1925
 BUREAU OF VITAL
 STATISTICS



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

FEB 7 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 1007State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 48412Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Harold David Neider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Jan 9 1925
(Month) (Day) (Year)

7. AGE

StillbornIF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Charles D. Neider

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Annie Marie Leach

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles D. Neider

(Address)

Blackfoot Idaho

15.

Filed

Jan 9 1925 Mr Walter E. Cat

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 9 1925, to Jan 9 1925
that I last saw h..... alive on.....
and that death occurred on the date stated above, at.....
The CAUSE OF DEATH* was as follows:Prolapse of cord

.....(Duration).....Yrs.....mos.....ds.

Contributory
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed)

W. Beck M. D.1/9 1925 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane City Conn19

20. UNDERTAKER

E. Beck

ADDRESS

Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent infection need not be stated unless important. Example: *Accidental drowning death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
694 214006959
COUNTY OF Bingham RECEIVED
FEB 7 1925
CITY OF Blackfoot BUREAU OF VITAL
No. R-1-3 St. Regist District No. 121 State File No. 128724
HOSPITAL _____ PRIMARY REGISTRATION DISTRICT NO. 2194 LOCAL REGISTRAR'S NO. 26
FULL NAME OF CHILD Baby Ormon
(Certificate of no value without full name of child)

SEX OF CHILD Female { Twin Triplet or other } and { Number in order of birth } Legitimate? Yes Date of birth Jan 14 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

FATHER		MOTHER	
FULL NAME	<u>Thomas Wm Ormon</u>	FULL MAIDEN NAME	<u>Selena May Reiser</u>
RESIDENCE	<u>Blackfoot</u>	RESIDENCE	<u>Blackfoot</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>44</u> (Years)	AGE AT LAST BIRTHDAY	<u>38</u> (Years)
BIRTHPLACE	<u>Utah</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farming</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:10 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 1925

(Signature) W. A. Beck

(Physician or midwife)

Address Blackfoot

Filed Feb 4 1925

Registrar.

Registrar.

JAN 31 1967

RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham District No. 121
 City of Blackfoot Registration District No. 2694
Wapello Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Ormond

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 48418

Registered No. 70

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single
 (Write the word.)

6. DATE OF BIRTH

Jan 14 1925
 (Month) (Day) (Year)

7. AGE

Stillborn
 IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Thomas Wm Ormond

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Selena May Reiser

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos W Ormond

(Address) Wapello Ida

15. Filed Jan 16 1925 Mr Walter R. Catlett

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn (and had been dead for several weeks)
Jan 14 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1925 to Jan 14 1925
stillborn
that I last saw him alive on Jan 14 1925

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Baby died some time before birth probably 4 weeks
 (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W W Beck M. D.

1/15/25 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL


Grave City Cem. 1-16 1925

20. UNDERTAKER

Ed Egli Blackfoot

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.



STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
843-102021-651
County of Franklin
City of Fairview, Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED

1925

CERTIFICATE OF BIRTH **128831**

No. St. Registration District No. 27 State File No.
Hospital Primary Registration District No. 2119 Local Registrar's No. 23

FULL NAME OF CHILD
(Certificate of no value without full name of child)

Sex of Child Male	<div>Twin Triplet or other?</div>	and {	Number in order of birth 2	Legiti- mate? Yes	Date of birth January 2, 1925 (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9		Number of child of this mother now living, including present birth 6	
FULL NAME LeRoy Hull	FATHER	FULL MAIDEN NAME Allaebell Weaver	MOTHER
RESIDENCE Fairview, Idaho.		RESIDENCE Fairview, Idaho.	
COLOR White	AGE AT LAST BIRTHDAY 38 (Years)	COLOR White	AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Whitney, Idaho.		BIRTHPLACE Millville, Utah.	
OCCUPATION Farmer		OCCUPATION Housewife	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive
Stillborn

 at 2. P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192.....
Registrar.

(Signature) G. W. Stiles
.....
Physician
(Physician or midwife)
Address 1 Preston, Idaho.
Filed Feb 4 1925 J. R. Butler
Registrar.

Name incorrectly added and copy issued on stillborn instead of on twin
1925-128844. Reversed and corrected 3/4/11 ly

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin
City of Fairview, Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 27
BUREAU OF VITAL STATISTICS
(STATISTICS) St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 48494
Local Registrar's No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

January 2, 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Fairview, Idaho

10. NAME OF

Father LeRoy Hull

11. BIRTHPLACE OF FATHER

(State or Country) Whitney, Utah

12. MAIDEN NAME OF MOTHER

Allaebell Weaver

13. BIRTHPLACE OF MOTHER

(State or Country) Millville, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb. 4 1925 J. R. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Don't Know
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 - 1925 to Jan 2 - 1925, that I last saw him alive on Jan 2 - 1925, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Baby had been dead probably 1 week before birth.
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. W. States M. D.
Jan 2 1925 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Fairview, Idaho
DATE OF BURIAL Jan. 3 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of FranklinCity of Weston, Idaho

FEB 9 1925

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. 493-21021893Registration District No. 27State File No. 128838

Hospital

Primary Registration District No. 2119Local Registrar's No. 19

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
ChildFemaleTwin
Triplet
or other?

and

Number
in order
of birthLegiti-
mate?YesDate of
birthJanuary 11, 1925

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1Number of child of this mother now living, including present birth 0FULL
NAME

FATHER

Lorenzo Mickelsen

RESIDENCE

Weston, Idaho.

COLOR

White

AGE AT LAST

BIRTHDAY

24

(Years)

BIRTHPLACE

Weston, Idaho.

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Cecelia Fitzpatrick

RESIDENCE

Weston, Idaho.

COLOR

White

AGE AT LAST

BIRTHDAY

20

(Years)

BIRTHPLACE

Salt Lake City, Utah.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 1.30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Physician

(Physician or midwife)

Address

Preston, Idaho.

Filed

Feb. 4, 1925

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED
FEB 10 1907
COUNTY OF
CITY OF
STATE OF
No. 123456789
HOSPITAL
FULL NAME OF CHILD
Certificate of birth without full name of child
Date of birth (Month) (Day) (Year)
Number of child in order of birth
Number of child of this mother now living including present birth
Number of child of this mother including present birth
MOTHER
FATHER
RESIDENCE
COLOR
AGE AT LAST BIRTHDAY
BIRTHPLACE
OCCUPATION
CERIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child who was born alive
on the date above stated.
When there was no attending physician or midwife the father, grandfather or another male relative a sufficient age should make the return. A sufficient child is one that neither breathes nor shows the evidence of life after birth.
(The names added from a supplemental report.)
108
Registrar
Address
Phone
Registrar

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

123456789

Primary Registration District No. 123456789

FULL NAME OF CHILD

(Certificate of birth without full name of child)

Sex of child (Male) (Female)
Date of birth (Month) (Day) (Year)
Number of child in order of birth
Number of child of this mother now living including present birth

What antiseptical solution was used in case?

Number of child of this mother now living including present birth

MOTHER
FATHER
RESIDENCE
COLOR
AGE AT LAST BIRTHDAY
BIRTHPLACE
OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born alive on the date above stated.

When there was no attending physician or midwife the father, grandfather or another male relative a sufficient age should make the return. A sufficient child is one that neither breathes nor shows the evidence of life after birth.

(The names added from a supplemental report.)

Registrar

Address

Phone

Registrar

1. PLACE OF DEATH

County of FranklinCity of Weston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan - 11 - 1925
(Month) (Day) (Year)

7. AGE

Never livedIF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. ☒

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) ☒

10. NAME OF FATHER

Lorenzo Mickelsen

11. BIRTHPLACE OF FATHER

(State or Country) Weston Idaho

12. MAIDEN NAME OF MOTHER

Acclia Fitzpatrick

13. BIRTHPLACE OF MOTHER

(State or Country) Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. States(Address) Preston Idaho

15.

Filed Feb. 5 - 1925 A. R. Crites
Local Registrar

CERTIFICATE OF DEATH

Registration District No. 27Primary Registration District No. 2119State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 48493Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Don't know
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 11 - 1925 to Jan 11 - 1925
that I never saw her alive on Jan 11 - 1925
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Deformed female child -
Dead when born

(Duration).....Yrs.....mos.....ds.

Contributory
(Secondary) ☒

(Duration).....yrs.....mos.....ds.

(Signed) G. W. States M. D.Jan 11 - 1925 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ☒ yrs.....mos.....days. In the State ☒ yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Weston

DATE OF BURIAL

Jan 11 - 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Fremont

RECEIVED

City of Ashton

FEB 4 1925

CERTIFICATE OF BIRTH

No. 815-127022389

BUREAU OF VITAL

Registration District No. 102State File No. 128846

Hospital

Primary Registration District No. 6Local Registrar's No. 1

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of
ChildMaleTwin
Triplet
or other?

}

and {

Number
in order
of birth
1st
(To be answered only in event of plural births)Legiti-
mate?yesDate of
birth1-27
(Month) (Day)1925
(Year)What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 7Number of child of this mother now living, including present birth 6FULL
NAMEFATHER
Arthur L. HooverFULL
MAIDEN
NAMEMOTHER
Eva Christensen Hoover

RESIDENCE

Marysville, Ida.

RESIDENCE

Marysville, Ida.

COLOR

whiteAGE AT LAST
BIRTHDAY 36
(Years)

COLOR

whiteAGE AT LAST
BIRTHDAY 31
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Section Hand

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn { at 2 A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

A. C. Merckham
Phys.

(Physician or midwife)

Address

Ashton, Ida.

Filed

2-1 1925A. C. Merckham

Registrar.

NOV 21 1968

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V, S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Fremont
City of Marysville, Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH
FEB 4 - 1925
BUREAU OF VITAL STATISTICS

(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 48496

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word)

6. DATE OF BIRTH

1 - 27 - 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
____ Yrs. ____ Mos. ____ ds. ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Ethan Thomas Hancock

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Eva Christensen Hancock

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethan Thomas Hancock(Address) Marysville, Ida.

15.

Filed 2-1-1925 Ed. Meacham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 - 27 - 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1 - 27 - 1925 to 1925

that I last saw h. Stillborn 1925

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Prematurity.stillborn_____
(Duration) ____ yrs. ____ mos. ____ ds.Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Ed. Meacham M. D.1925 (Address) Arden, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

19. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death ____ yrs. ____ mos. ____ days. State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Marysville, Ida. 1 - 27 - 1925

20. UNDERTAKER

none ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Fremont

City of Ashton

No. 866-227022389

RECEIVED
FEB 4 1925

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

St. Registrar District No. 102

State File No.

128847

Hospital

Primary Registration District No. 6

Local Registrar's No. 1

FULL NAME OF CHILD

Still Born

(Certificate of no value without full name of child)

Sex of
Child

Female

Twin
or other?
no

and { Number
in order
of birth 2nd

Legiti-
mate?

yes

Date of
birth

1 - 27 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth 8

Number of child of this mother now living, including present birth 6

FULL
NAME

FATHER
Ethel I. Hancock

RESIDENCE

Marysville, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

36
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Section Hand

FULL
MAIDEN
NAME

MOTHER
Eva Christensen Hancock

RESIDENCE

Marysville, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

31
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive { at 2:15 A. M.
on the date above stated. { Stillborn {

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

[Signature]
Phys.

(Physician or midwife)

Address

Ashton, Idaho

Filed

2-1-1925

Registrar.

Registrar.

NOV 21 1968

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Freemont*City of *Marysville*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(No.)

(St.)

RECEIVED
FEB 4 1925
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

Registration District No. *102*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *48497*Local Registrar's No. *2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word)

6. DATE OF BIRTH

1-27-1925
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day how many
— hrs. or
— min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Elmer Thos. Hancock

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Eva Christina Hancock

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *Marysville, Ida.*

15.

Filed

2/1/1925
Elmer Thos. Hancock
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1-27-1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-27-1925 to *1-27-1925*

that I last saw him *alive* *Stillborn* 19..

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

prematurity
Stillborn

(Duration) — yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

Elmer Thos. Hancock M. D.

1/19/25 (Address) *Marysville, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — days. State — yrs. — mos. — ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Marysville, Ida.

DATE OF BURIAL

1-27-1925

20. UNDERTAKER

none

ADDRESS

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

413104-030-795
PLACE OF BIRTH

RECEIVED

DEPA.

BUREAU

FEB 12 1925

CERTIFICATE

S128920

County San LuisCity of Salmon

BUREAU OF VITAL

No. _____ St. _____

District No. 41

File _____

Hospital _____

Primary Registration District No. 2116

Registered No. _____

FULL NAME OF CHILD

Harvey P. Matthews

(Certificate of no value without full name of child.)

Sex of
Childm.Twin
Triplet
or other?{ and } Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?YesDate of
birthJan 41925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth

3

Number of child of this mother now living, including present birth

3FULL
NAME

FATHER

Winiford B. Matthews

RESIDENCE

SalmonFULL
MAIDEN
NAME

MOTHER

Paul Pierce

RESIDENCE

Salmon

COLOR

WhiteAGE AT LAST
BIRTHDAY7/3

(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY7/1

(Years)

BIRTHPLACE

Montana

BIRTHPLACE

Montana

OCCUPATION

Common laborer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.Salmon

(Born alive or stillborn)

M.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Chas. F. Hammer

(Physician or midwife)

Give names added from a supplemental report.

_____, 19____

Address _____

Filed

2-101925M. H. Davis

Registrar.

Registrar.

10

11

12

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of OncidaCity of MaladNo. 266130036993

St.

RECEIVED
FEB 2 1925

BUREAU OF VITAL CERTIFICATE OF BIRTH

Register District No. 46

State File No.

128995

Hospital

Primary Registration District No. 2069Local Registrar's No. 15-

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

}

and {

Number
in order
of birth3Legiti-
mate?yesDate of
birth1301925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Argrol

Number of child of this mother, including present birth

3

Number of child of this mother now living, including present birth

2FULL
NAME

FATHER

Fred James Bowcutt

RESIDENCE

Malad

COLOR

white

AGE AT LAST

BIRTHDAY

32

(Years)

BIRTHPLACE

Fielding, Utah

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Sara Pearl Richards

RESIDENCE

Malad

COLOR

white

AGE AT LAST

BIRTHDAY

29

(Years)

BIRTHPLACE

Malad

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

[Signature]

(Physician or midwife)

Address

Malad, Idaho

Filed

1/31

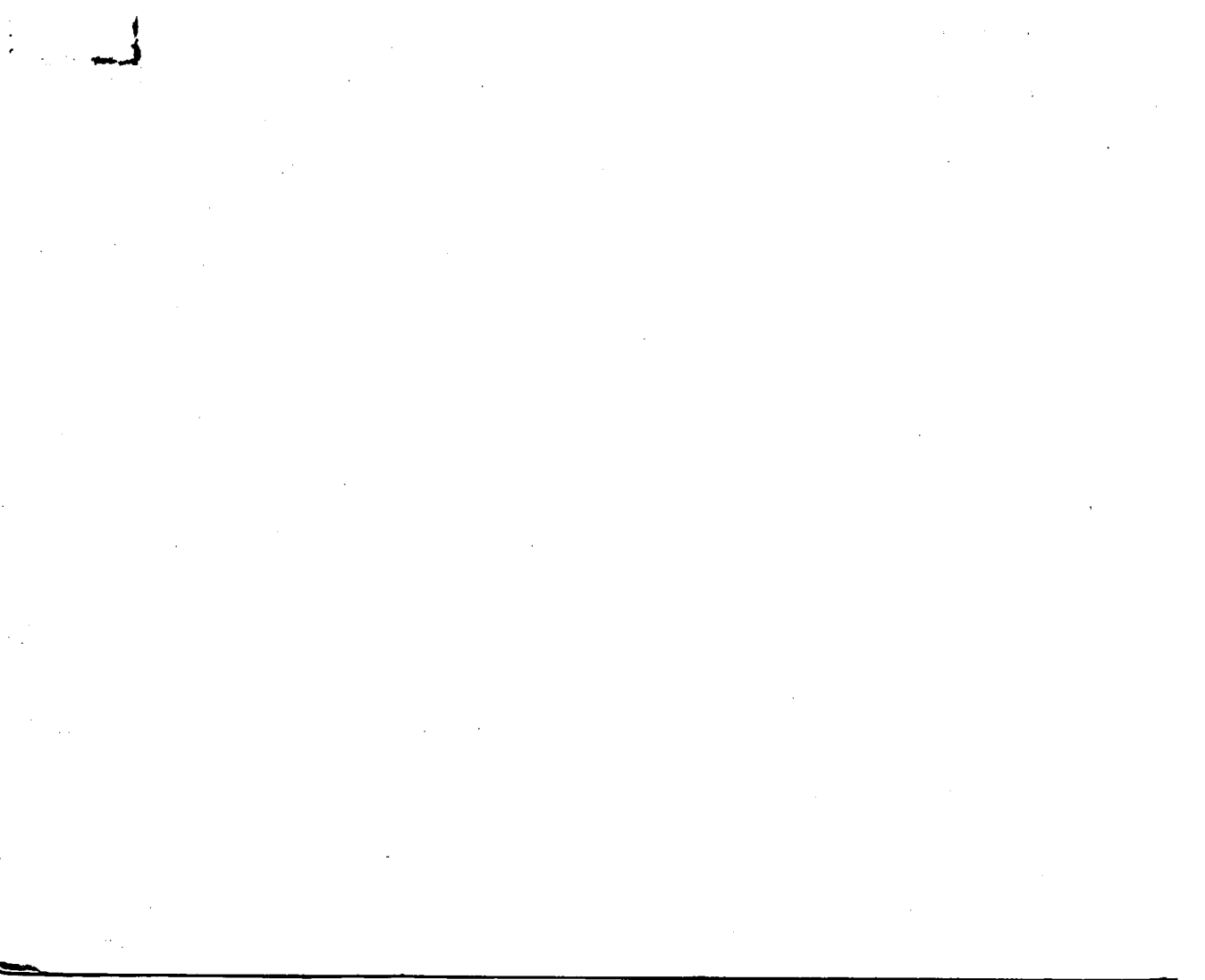
1925

J. M. News

Registrar.

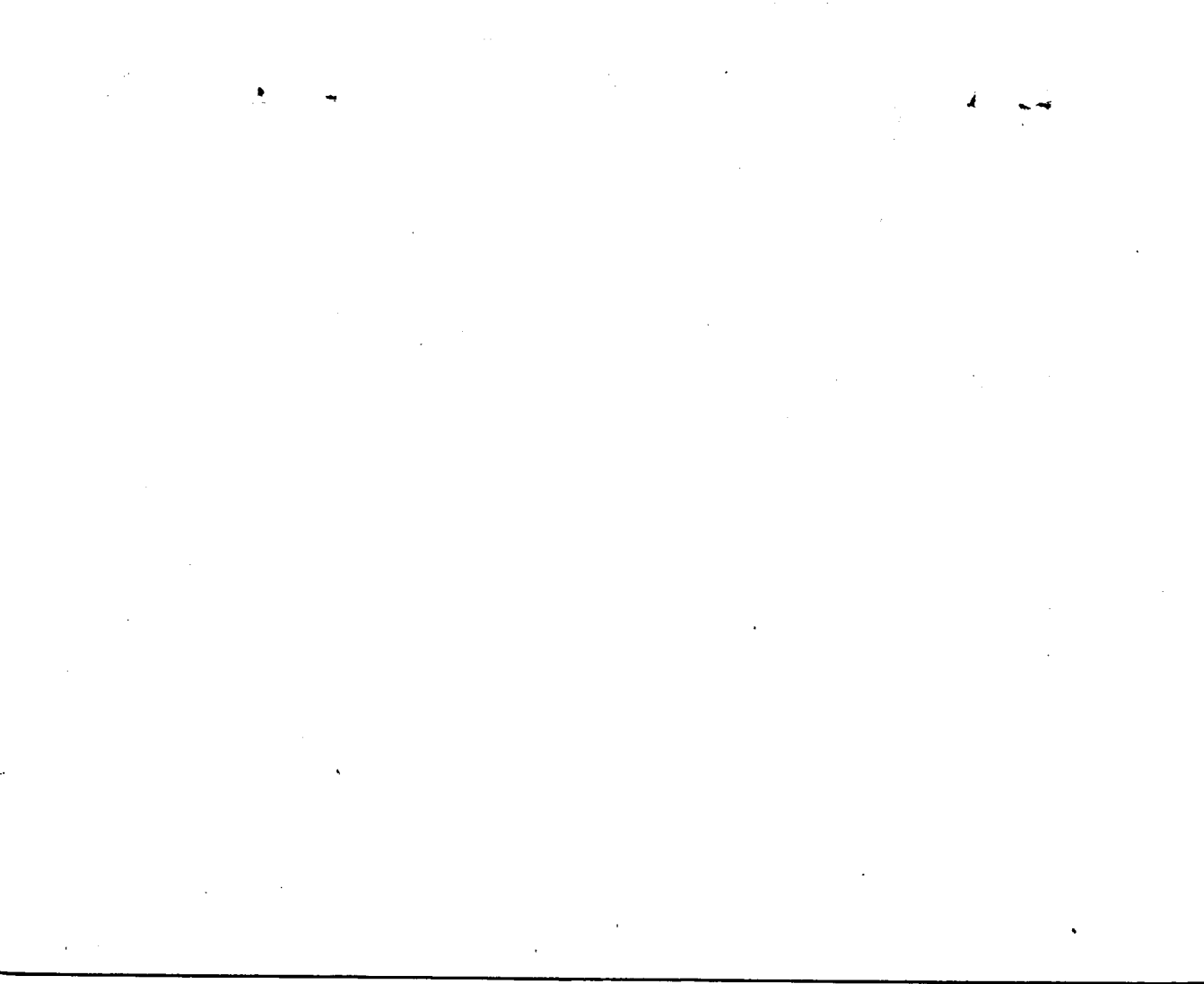
Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 389116 339 684		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		S	
County of <u>Boise</u>		FEB 7 1925			
City of <u>Am. Falls</u>		BUREAU OF VITAL CERTIFICATE OF BIRTH			
No.	St.	Registration District No. <u>25</u>	State File No. <u>129010</u>		
Hospital		Primary Registration District No. <u>2072</u>	Local Registrar's No. <u>722</u>		
FULL NAME OF CHILD					
(Certificate of no value without full name of child)					
Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>1 16 1924</u>	
		(To be answered only in event of plural births)		(Month) (Day) (Year)	
What bactericidal solution was used in eyes?					
Number of child of this mother, including present birth <u>4</u>		Number of child of this mother now living, including present birth <u>4</u>			
FATHER			MOTHER		
FULL NAME <u>Arthur R. Thiel</u>			FULL MAIDEN NAME <u>Alta Wynne</u>		
RESIDENCE <u>Am. Falls, Ida</u>			RESIDENCE <u>Am. Falls, Ida</u>		
COLOR <u>white</u>		AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>white</u>		AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Illinois</u>			BIRTHPLACE <u>Kansas</u>		
OCCUPATION <u>Acetyl Welder</u>			OCCUPATION <u>Housewife</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*					
I hereby certify that I attended the birth of this child, who was <u>Born alive</u> at <u>4:20 P. M.</u> on the date above stated.					
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.					
Give names added from a supplemental report., 192....					
Registrar.			Address <u>Am. Falls, Ida</u>		
Filed <u>2-4</u> 192 <u>5</u>			Registrar. <u>Y. G. Logan</u>		



FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *Boise*City of *Am. Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Thiel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH.

Jan. 16 1925
(Month) (Day) (Year)

7. AGE

stillborn
Pre-mature
Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Arthur R. Thiel

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Alta Wymann

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed *4-6**1925**Genevieve Roth*

Local Registrar

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

49333

Registered No.

224

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 - 16 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pre-mature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *V. B. Logan* M. D.*Jan. 16 1925* (Address) *Am. Falls*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Am. Falls**1-16 1925*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

859-122-003-695
County of Bannock

City of Pease

No. 1222011 St.

Hospital

FULL NAME OF CHILD

John Herman
(Certificate of no value without full name of child.)

STATE OF IDAHO

RECEIVED

FEB 14 1925

BUREAU OF VITAL
STATISTICS

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 2161

File No. 129155

Registered No. 649

Sex of
Child

male

Twin
Triplet
or other?

(To be answered only in event of plural births)

and

Number
in order
of birth

1

Legiti-
mate?

yes

Date of
birth

1-22

1925

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? Steel Barn

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

John Herman

RESIDENCE

722 2011th

COLOR

white

AGE AT LAST
BIRTHDAY

5-3
(Years)

BIRTHPLACE

Herman's

OCCUPATION

plasterer

FULL
MAIDEN
NAME

MOTHER

Denise Furberg

RESIDENCE

722 2011th

COLOR

white

AGE AT LAST
BIRTHDAY

38
(Years)

BIRTHPLACE

Russier

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Phy. J. Furberg at 0:30 P. M.
(Born alive or Stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. Furberg

(Physician or midwife)

Give names added from a supplemental report.

Address

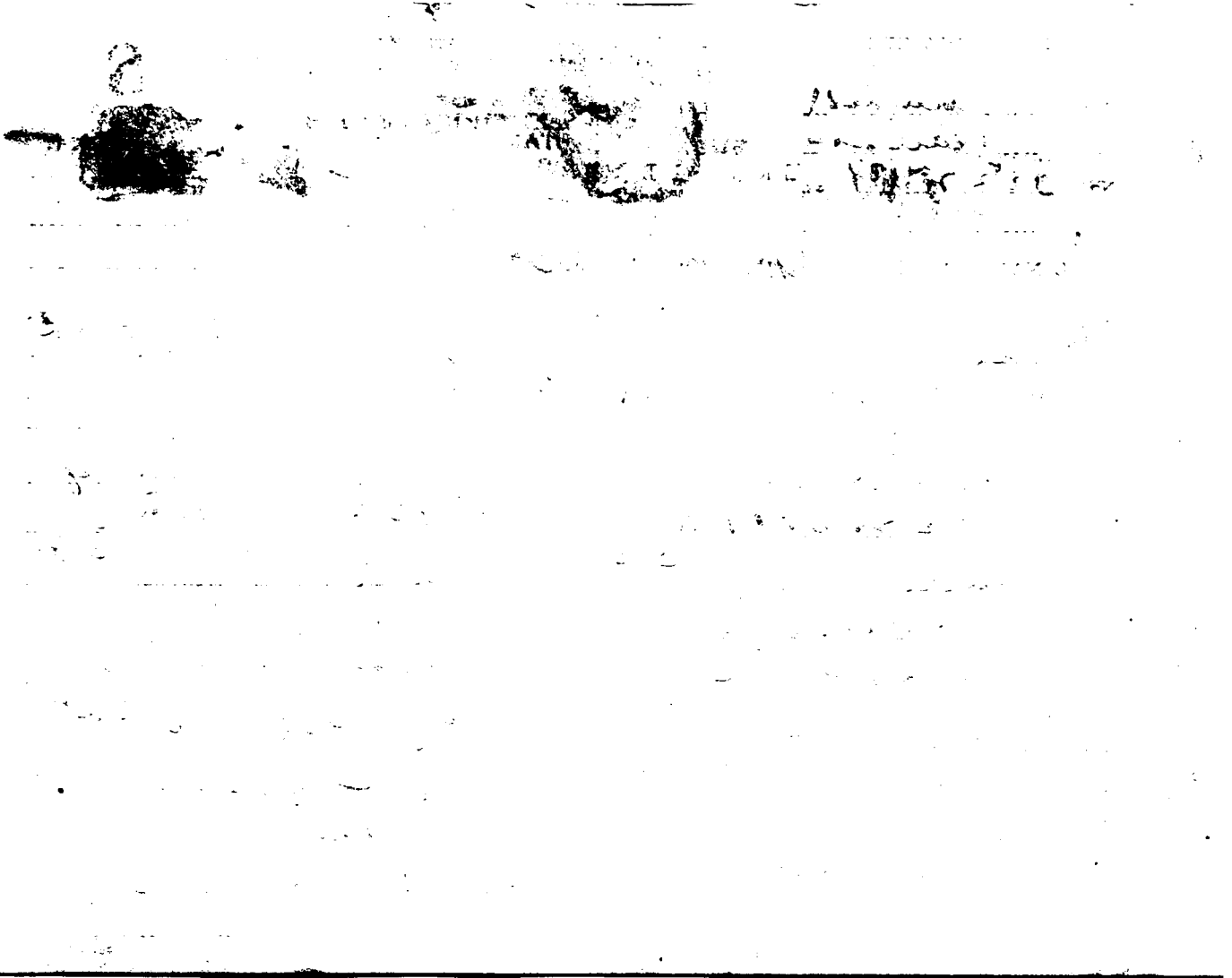
454 E. Garfield

Filed

2/1 1925

Registrar.

Registrar.



DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho

MAR 12 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place { CITY Pocatello FILE NO. 129155
 of { ST. 22nd DATE OF BIRTH Jan 22-23
 Birth { COUNTY Bannock SEX OF CHILD Male
 FATHER John MOTHER Jessie Kimball
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

RECEIVED
 MAR 18 1925
 BUREAU OF VITAL
 STATISTICS

John Herman

John Herman
 Signature of Father or Mother.

Dear Sirs: I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named child. I am sorry to hear that the child is not well. I have been very anxious to see the child and to hear from you. I have been very busy lately, but I have been thinking of you and the child all the time. I hope to hear from you again soon.

I am, Sir, very respectfully,
 Yours very truly,
 J. M. Smith
 (Mother's Name)

I hereby certify that the child herein described has been named:

 Signature of Father or Mother.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of BannockCity of DowneyNo. 219.113.003.692

RECEIVED

FEB 17 1925

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

129171

No. 219.113.003.692 State File No. 83Hospital _____ Primary Registration District No. 2160 Local Registrar's No. 89FULL NAME OF CHILD none

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>yes</u>	Date of birth <u>Jan-13-1925</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 1 Number of child of this mother now living, including present birth none

FATHER
FULL NAME Isaac W. Barnes
RESIDENCE Downey, Idaho
COLOR white AGE AT LAST BIRTHDAY 27
(Years)
BIRTHPLACE Hayville, Utah
OCCUPATION Boatman

MOTHER
FULL MAIDEN NAME Elizabeth Wise
RESIDENCE Downey, Idaho
COLOR white AGE AT LAST BIRTHDAY 25
(Years)
BIRTHPLACE Gorland, Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 6 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) A. J. Berggren, M.D.
(Physician or midwife)Address Downey, IdahoFiled Jan. 15-1925 Mar. C. Coffin

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE PUBLIC HEALTH SERVICE ACT OF 1906, AS AMENDED, ONLY WHEN IT IS FILED IN THE OFFICE OF THE REGISTRAR OF VITAL STATISTICS, AND WHEN IT IS ACCOMPANIED BY THE REQUIRED FEE.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1917

CERTIFICATE OF BIRTH

RECEIVED
FEB 1 1917

Hospital No. _____ County of _____
City of _____
No. _____
Primary Registration District No. _____ Local Registrar's No. _____
State No. _____

FULL NAME OF CHILD

(Child's name to be given without full name of child)
Sex of Child _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Sex of Child _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
(To be answered only in event of plural births)

What photostatic solution was used in copy?

Number of child in this family, including present birth _____
Number of child in this family, including present birth _____
FATHER
FULL NAME _____
MOTHER
FULL NAME _____

COLOR _____ AGE AT LAST BIRTHDAY _____
BIRTHPLACE _____
OCCUPATION _____
BIRTHPLACE _____
OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____
on the date above stated.

When there was no attending physician or midwife, then the father, mother or other person should make this return. A child born in one place and another place, and shows other evidence of the other birth, give names added from a supplemental report.

(Signature of midwife)

Registrar

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
FEB 17 1925
BUREAU OF VITAL STATISTICS
IDAHO

1. PLACE OF DEATH

County of Bannock
City of Payson

CERTIFICATE OF DEATH

District No. 82
Primary Registration District No. 2168
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 48636
Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME none

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____
(Write the word.)

6. DATE OF BIRTH Jan 13 1925
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day how many _____ hrs. or _____ min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE Payson, Idaho
(State or Country)

10. NAME OF FATHER Isaac W. Barnes

11. BIRTHPLACE OF FATHER Keynville, Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Wise

13. BIRTHPLACE OF MOTHER Goshland, Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isaac Barnes
(Address) Payson, Idaho

15. Filed Feb 14 1925 Mary C. Coffin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 13 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1925 to Jan 13 1925, that I last saw him at birth and that death occurred on the date stated above, at Payson, Idaho

The CAUSE OF DEATH* was as follows:
Difficult Birth
Extraction

(Duration) Yrs. mos. ds.
Contributory Premature
(Secondary)
(Duration) yrs. mos. ds.
(Signed) J. H. Hartman M. D.
(Address) Payson, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ In the _____ days State _____ yrs. mos. days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Payson, Idaho DATE OF BURIAL 1-14-1925

20. UNDERTAKER none ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

4935112006-238
PLACE OF BIRTH

RECEIVED
MAR 6 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Starling

No. St.

Registration District No. 116

State File No.

Hospital

Primary Registration District No. 2/5

Local Registrar's No. 891

FULL NAME OF CHILD Edmund Elwood Miller - (Steel born)

(Certificate of no value without full name of child)

Sex of
Child

male

Twin
Triplet
or other?

—

and {

Number
in order
of birth

—

Legiti-
mate?

yes

Date of
birth

ph 12

1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9

Number of child of this mother now living, including present birth 7

FULL
NAME

FATHER

John Miller

RESIDENCE

Starling Ida

COLOR

White

AGE AT LAST
BIRTHDAY

41
(Years)

BIRTHPLACE

Russia

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Caroline Schwiegent

RESIDENCE

Starling Ida

COLOR

White

AGE AT LAST
BIRTHDAY

25
(Years)

BIRTHPLACE

Russia

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Born alive { at Starling M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

M. C. Mortensen M.D.

(Physician or midwife)

Address

Starling Ida

Filed

Feb 1 1925

Registrar.

Registrar.

[illegible]

Five names added from a confidential report
which other witnesses to the attack
could be one that neither witnesses nor
any should make this claim a likelihood
of another than the latest householder
when there was no reasonable possibility
on the date above stated.

I hereby certify that I examined the birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

RESIDENCE	COLOR	AGE AT LAST BIRTHDAY	BIRTHPLACE	OCCUPATION
RESIDENCE	COLOR	AGE AT LAST BIRTHDAY	BIRTHPLACE	OCCUPATION

[illegible]

(Certificate of no value without full name of child)

CHILD NAME OF CHILD

Presently Registered District No.

Registration District No.

State File No.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. 158808

1. PLACE OF DEATH

County of Bingham Registration District No. 116
 City of Sterling Registration District No. 2195

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helmut Edmond Miller

CERTIFICATE OF DEATH

48666

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. _____

Registered No. 102

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
 (Write the word.)

6. DATE OF BIRTH

Feb 12 1925
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

John Miller

11. BIRTHPLACE OF FATHER

(State or Country) Russia

12. MAIDEN NAME OF MOTHER

Caroline Schwegert

13. BIRTHPLACE OF MOTHER

(State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Miller

(Address) Sterling Idaho

15.

Filled Feb 12 1925 M. C. Markum
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 12 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
 that I last saw h. _____ alive on _____ 19____
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born - apparently dead
some days before birth -
Cause of death not found -

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. C. Markum M. D.

Feb 12 1925 (Address) Aberdeen Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pleasant Valley

DATE OF BURIAL

Feb 13 1925

20. UNDERTAKER

Friends

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

157 217-014-239
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon
City of Nampa
No. R.R. 4 St. Registration District No. 7 State File No. 129289

RECEIVED
MAR 3 1925
BUREAU OF VITAL
STATISTICS

Hospital _____ Primary Registration District No. 206 Local Registrar's No. 25

FULL NAME OF CHILD Louis Wanda Agenboard
(Certificate of no value without full name of child)

Sex of Child F. Twin Triplet or other? _____ } and { Number in order of birth 5 Legitimate? yes Date of birth 2-17-1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Richard Agenboard
RESIDENCE Nampa R.R. 4
COLOR W. AGE AT LAST BIRTHDAY 39
(Years)
BIRTHPLACE S. Dakota
OCCUPATION Rancher

MOTHER
FULL MAIDEN NAME Jennie Straub
RESIDENCE Nampa R.R. 4
COLOR _____ AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Texas
OCCUPATION House-wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 2 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. J. C. Robinson
Physician
(Physician or midwife)

Address 1817 4th St S.
Filed Mar 2 1925 Martaby
Registrar.

THIS IS A DEPARTMENT OF HEALTH FORM
 TO BE FILLED BY THE ATTENDING PHYSICIAN OR MIDWIFE
 IN CASE OF A BIRTH OR STILLBIRTH
 TO BE FILED IN THE BIRTH RECORDS OF THE
 COUNTY OF ...

PLACE OF BIRTH

RECEIVED
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF PUBLIC HEALTH
 STATE OF OHIO

CERTIFICATE OF BIRTH 133280

No. _____ County of _____ City of _____
 Hospital _____
 Full Name of Child _____
 Sex of Child _____
 Date of Birth _____
 Time of Birth _____
 Weight _____
 Length _____
 Head _____
 Chest _____
 Arm _____
 Leg _____
 Feet _____
 Birth _____
 Month _____
 Day _____
 Year _____

What bacterioid solution was used in case _____
 Number of child of this mother, including present birth _____
 Number of child of this mother, now living, including present birth _____
 Full Name of Father _____
 Full Name of Mother _____
 Residence of Father _____
 Residence of Mother _____
 Color of Father _____
 Color of Mother _____
 Birthplace of Father _____
 Birthplace of Mother _____
 Occupation of Father _____
 Occupation of Mother _____
 Age at Last Birthday of Father _____
 Age at Last Birthday of Mother _____
 Birthplace of Child _____
 Occupation of Child _____
 Color of Child _____
 Residence of Child _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____
 on the date above stated.
 When there was no attending physician or midwife, then the father, householder, or other person, should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
 Give names added from a supplemental report _____
 Address _____
 Signature _____
 Date _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia **RECEIVED**
City of Burley **FEB 19 1925**
No. 843-128 016 493 **BUREAU OF VITAL**
St. **STATISTICS** District No. 117 File No. 129367
Hospital _____ Primary Registration District No. 2196 Registered No. 3051
FULL NAME OF CHILD Stacy Skult
(Certificate of no value without full name of child.)

Sex of Child Male Twin Triplet or other? — and — Number in order of birth — Legitimate? Yes Date of birth Jan 28 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes? Ag Noz

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER		MOTHER	
FULL NAME	<u>Stan Skult</u>	FULL MAIDEN NAME	<u>Carthain Mitchell</u>
RESIDENCE	<u>Burley</u>	RESIDENCE	<u>Burley</u>
COLOR	<u>White</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>46</u> (Years)	AGE AT LAST BIRTHDAY	<u>40</u> (Years)
BIRTHPLACE	<u>Sweden</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>mother</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born dead at 8:20 a. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F H Center
M.D.
(Physician or midwife)

Give names added from a supplemental report.

Address Burley, Ida
Filed 2-9 1925 Dr. J. C. Patterson
Registrar.

11. 12

11. 12

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of CassiaCity of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Kuilt.

RECEIVED DATE OF DEATH

Register of Deaths No. 117
BUREAU OF VITAL STATISTICS District No. 2196
(No. STATISTICS) St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 48751Local Registrar's No. 763

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Jan. 28 = 1925
(Month) (Day) (Year)

7. AGE

Still Born.
Yrs. Mos. ds.IF LESS than 1 day how many
.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burley, Ida.

10. NAME OF FATHER

Samuel Kuilt.

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Catharine Mitchell

13. BIRTHPLACE OF MOTHER

(State or Country) Hopewell, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel Kuilt(Address) Burley Ida. R.F. d. # 3.

15.

Filed 2-29 1925 H. J. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 28 1925
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Jan. 28 1925 to Jan 28 1925, that I last saw him on Jan 28 1925, and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:Premature birth(Duration) yrs. mos. ds.
Contributory Podalic Position Delivery
(Secondary)(Duration) yrs. mos. ds.
(Signed) J. H. Curtis M. D.
19. (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.DATE OF BURIAL
Jan. 29-1925

20. UNDERTAKER

L. B. Gallagher

ADDRESS

Burley Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train**—**accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia
City of Burley
No. 257 214 016 289 St. BUREAU OF VITAL STATISTICS District No. 117 State File No. 129374
Hospital _____ Primary Registration District No. 2196 Local Registrar's No. 3058
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Feb. 14</u> <u>1925</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? Silver Nitrate 1% Sol.

Number of child of this mother, including present birth 11 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME

L. Segal

RESIDENCE

Burley, Ida.

COLOR

White

AGE AT LAST BIRTHDAY 33
(Years)

BIRTHPLACE

Austria

OCCUPATION

Tailor

MOTHER
FULL MAIDEN NAME

Veda Byington

RESIDENCE

Burley, Ida.

COLOR

White

AGE AT LAST BIRTHDAY 26
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Dr. J. C. Patterson

Physician

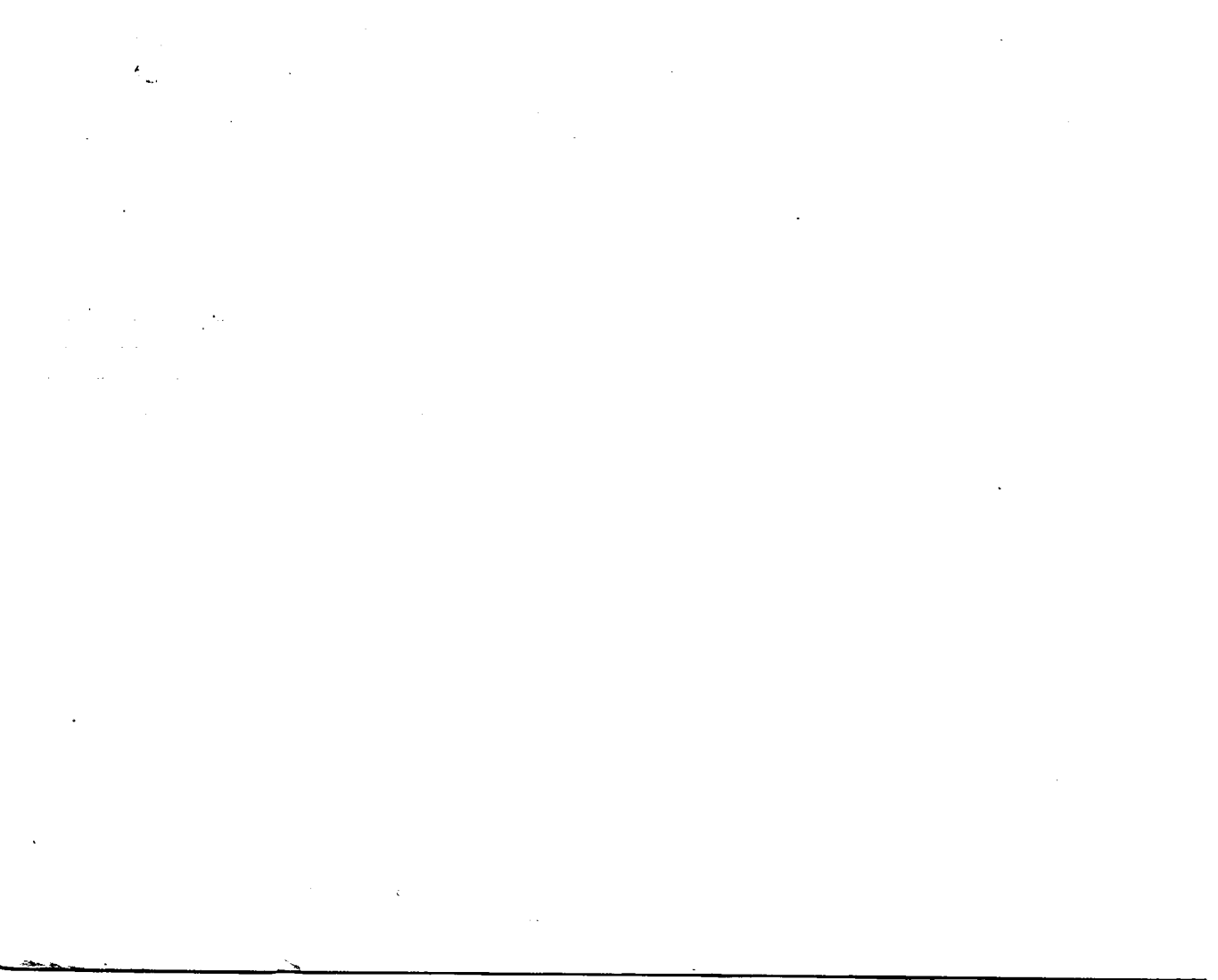
(Physician or midwife)

Address Burley, Ida.

Filed 2-24 1925

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
MAR 12 1925
BUREAU OF VITAL STATISTICS

S

County of Chesler
City of Burley
No. 213-21016-539 St.

CERTIFICATE OF BIRTH
Registration District No. 117 State File No. 129381

Hospital..... Primary Registration District No. 2196 Local Registrar's No. 3065

FULL NAME OF CHILD.....
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>2 - 11 - 1925</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? Argyrol Solution

Number of child of this mother, including present birth 5 - Number of child of this mother now living, including present birth 3 -

FULL NAME <u>John Balasta</u>	FATHER	FULL MAIDEN NAME <u>Antonia Elisarraray</u>	MOTHER
RESIDENCE <u>Burley, Ida</u>		RESIDENCE <u>Burley, Ida</u>	
COLOR <u>- Latin -</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>- Latin -</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Mexico City, Mexico</u>		BIRTHPLACE <u>Mexico City, Mexico</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING RHYSIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Born alive at 11 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G. H. Cooper
Physician
(Physician or midwife)

Give names added from a supplemental report.
....., 192.....
Address Burley, Idaho
Filed 3-10 1925 Dr. J. C. Patterson
Registrar.

CERTIFICATE OF BIRTH

1933

Primary Registration District No. _____

STATE NAME OF CHILD

(Certificate of an infant without full name of child)

Sex of Child () Male () Female
Date of Birth (Month) _____ (Day) _____
Time of Birth () AM () PM

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

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Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

Place of Birth () Hospital () Home () Other _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED

CERTIFICATE OF DEATH

18717

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Assia
County of Burley Registration District No. 117
City of Burley (No. 2196, St.)
BUREAU OF VITAL STATISTICS

File No. _____

Registered No. 771

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Latin 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH 2 - 11 - 1925
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. ✓
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Burley Ida

10. NAME OF FATHER John Bolask

11. BIRTHPLACE OF FATHER Mexico - City Mexico
(State or Country)

12. MAIDEN NAME OF MOTHER Antonia Elvararraray

13. BIRTHPLACE OF MOTHER Mexico City Mexico
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Bolask
(Address) Burley Ida

15. Filed 3-10 1925 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH. 189

16. DATE OF DEATH 2 - 11 - 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191
that I last saw h. ✓ alive on 191
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Stillborn
Probably Lethic
(Duration) ✓ yrs. _____ mos. ✓ ds.

Contributory (Secondary) _____
(Duration) ✓ yrs. _____ mos. _____ ds.
(Signed) G. H. Cooper M. D.
2-12-2519 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Burley Ida DATE OF BURIAL 2-12 1925

20. UNDERTAKER Home ADDRESS _____

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know ~~for~~ the kind of work and also (b) the nature of the business of industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

MAR 9 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of *Elmore*BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH 129409

City of *King Hill*No. *245108-020168* St.Registration District No. *35*

File No. _____

Hospital _____

Primary Registration District No. *2021*

Registered No. _____

FULL NAME OF CHILD

Ernest Eugene Sundvall
(Certificate of no value without full name of child.)Sex of
Child*Male*Twin
Triplet
or other?

{ and }

{ Number
in order
of birth }*1*Legiti-
mate?*yes*Date of
birth*Jan 6**1925*
(Month) (Day) (Year)What bactericidal solution was used in eyes? *None*Number of child of this mother, including present birth... *1*Number of children of this mother now living, including present birth... *1*FULL
NAME

FATHER

Ernest Sundvall

RESIDENCE

King Hill Idaho

COLOR

White

AGE AT LAST

BIRTHDAY *30*
(Years)

BIRTHPLACE

Sweden

OCCUPATION

*Farmer*FULL
MAIDEN
NAME

MOTHER

Hilma Johnson

RESIDENCE

King Hill Idaho

COLOR

White

AGE AT LAST

BIRTHDAY *24*
(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Jan 6 1925* at *6:30* *A*. M.
on the date above stated. (Resident or stillborn)*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

*J. W. Davis M.D.**Elmer's Time Idaho*

(Physician or midwife)

Give names added from a supplemental report.

Address

Elmer's Time Idaho

Filed

*Jan 9 1925**J. W. Davis*

Registrar.

Registrar.



6

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho

MAR 1 9 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * *

Place of Birth { CITY King Hill FILE NO. 129409
 { ST. Idaho DATE OF BIRTH Jan 6 1916
 { COUNTY Elmore SEX OF CHILD Male
 FATHER E. J. Sundvall MOTHER Anna A. Johnson
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Ernest Eugene Bernadine

Mrs. E. A. Sundvall
Signature of Father or Mother

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of *Cwyher*
City of *Knig Hill*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmarried

RECEIVED
MAR 9 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *35*

Registration District No. *2021*

(No. St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *48759*

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6. DATE OF BIRTH

Jan. 6² 1925
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day how many
..... hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Ernest Sundvall

11. BIRTHPLACE OF FATHER

(State or Country) *Sweden*

12. MAIDEN NAME OF MOTHER

Hilma Johanson

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ernest Sundvall*

(Address) *Knig Hill Idaho*

15.

Filed *Jan 7² 1925* *J. W. Davis*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 6² 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 6² 1925 to *Jan 6² 1925*;
that I last saw h..... alive on *Stillborn Jan 6¹ 1925*;

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. W. Davis*

Jan 6 1925 (Address) *Ernest Sundvall's home Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Knig Hill Idaho

DATE OF BURIAL

Jan 7 1925

20. UNDERTAKER

Ernest Sundvall

ADDRESS

Knig Hill Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia;** **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles;** **Whooping cough;** **Chronic valvular heart disease;** **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.;** **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident;** **Revolver wound of head—homicide;** **Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Jerome **RECEIVED** FEB 17 1925
 City of Haystack **BUREAU OF VITAL STATISTICS** CERTIFICATE OF BIRTH
 No. 155-115027-613 St. Registration District No. 23 State File No. 129474
 Hospital _____ Primary Registration District No. 1017 Local Registrar's No. _____
 FULL NAME OF CHILD Carl James

(Certificate of no value without full name of child)

Sex of Child m Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimacy ye Date of birth Jan 15 1925
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? noNumber of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 1

FATHER
 FULL NAME Lawrence S. James
 RESIDENCE Haystack
 COLOR wh AGE AT LAST BIRTHDAY 36 (Years)
 BIRTHPLACE Ida
 OCCUPATION Farmer

MOTHER
 FULL MAIDEN NAME Nana Walker
 RESIDENCE Haystack
 COLOR wh AGE AT LAST BIRTHDAY 32 (Years)
 BIRTHPLACE Ida
 OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6³⁰ A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. H. Berry, M.D.

(Physician or midwife)

Address Haystack IdaFiled Feb 16 1925 - E. D. Piper, M.D.

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THIS CARD IS TO BE FILLED OUT BY THE PHYSICIAN OR MIDWIFE ATTENDING THE CHILD AT THE TIME OF BIRTH AND IS TO BE RETURNED TO THE BUREAU OF VITAL STATISTICS WITH THE BIRTH CERTIFICATE.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS
FEB 1 1932

128434

County of _____
City of _____
Not _____
Primary Registration District No. _____
Local Registrar _____
Hospital _____
FILL NAME OF CHILD _____
(Certificate of no use without full name of child)
Sex of Child _____
Date of Birth _____
Time of Birth _____
Month _____
Year _____
Number of Birth _____
Number in order _____
and _____
Total _____
Child _____

What pathological condition was noted in _____
MOTHER
NAME _____
RESIDENCE _____
COLOR _____
AGE AT LAST BIRTHDAY _____
BIRTHPLACE _____
OCCUPATION _____
BIRTHPLACE _____
OCCUPATION _____
RESIDENCE _____
NAME _____
AGE AT LAST BIRTHDAY _____
BIRTHPLACE _____
OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.
When there was no attending physician or midwife, then the father, nonresident, should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
This return asked from a supplemental report.
Address _____
Signed _____
Date _____
(Physician or midwife)
(Signature)

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of JarvisCity of Hazlet

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

1925
RECEIVED
FEB 17 1925
BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

Registration No. 23Registration District No. 7017-2017

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 48781

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the words)

6. DATE OF BIRTH

Jan 15 1925
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hazlet Ida

10. NAME OF FATHER

Lawrence S Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Kora Walker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. S. Jensen

(Address)

Hazlet, Ida

15.

Filed

Feb 161925E. D. Piper M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 15 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 15 1925 to Jan 15 1925
that I last saw him Still born 1925
and that death occurred on the date stated above, at 8 M.

The CAUSE OF DEATH* was as follows:

Premature separation of placenta

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. D. Piper

M. D.

1-15-25 (Address) Hazlet

*State the Disease Causing Death; or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hazlet Cemetery 1-15-1925

20. UNDERTAKER

ADDRESS

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at a birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Kootenai

City of Cornwall

No. 469-117028-893

Registration District No. 30

State File No.

Hospital

Primary Registration District No. 1051

Local Registrar's No. 1234

FULL NAME OF CHILD

A. E. Mortlock Jr.
(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

Yes

Date of birth

Feb. 17

1925

(Month) (Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 3

FULL NAME

FATHER

A. E. Mortlock

RESIDENCE

Cornwall

COLOR

White

AGE AT LAST

BIRTHDAY

38
(Years)

BIRTHPLACE

Canada

OCCUPATION

Labourer

FULL MAIDEN NAME

MOTHER

Marquet, William

RESIDENCE

Cornwall

COLOR

White

AGE AT LAST

BIRTHDAY

35
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Dr. wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 11 - P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

1108 3rd
A. E. Mortlock
(Physician or midwife) Father

Address

Cornwall Idaho

Filed

Mar 4 1925

Registrar.

This is to certify that the child named above was born at the place and date stated above and that the mother and father of the child are the persons named above and that the child is the legitimate issue of the marriage of the mother and father named above.

Give names added from a supplemental report.
 *When there was no attending physician or midwife then the father, householder, etc. should make this return. A stillborn child is one that neither previous nor shows other evidence of the later birth.
 (Signature)
 Address
 Filed

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was { Stillborn } at { Born alive } on the date above stated.

(Physician or midwife)
 Address
 Filed

OCCUPATION BIRTHPLACE BIRTHDAY (Year) COLOR AGE AT LAST BIRTHDAY (Year) RESIDENCE
 OCCUPATION BIRTHPLACE BIRTHDAY (Year) COLOR AGE AT LAST BIRTHDAY (Year) RESIDENCE

FATHER FULL NAME MAIDEN NAME RESIDENCE
 MOTHER FULL NAME MAIDEN NAME RESIDENCE

Number of child of this mother, including present birth
 Number of child of this mother now living, including present birth

First fraternal sibling was such in years
 Sex of child
 (To be answered only in case of placental twins)
 and { Numbered in order of birth }
 (To be answered only in case of placental twins)
 Date of birth (Month) (Day) (Year)

FULL NAME OF CHILD
 (To be answered only in case of placental twins)

Hospital
 Estimated Registration District No. Local Registrar's No.

No. 1 Registration District No. State File No.

City of
 County of

PLACE & DATE
 REGISTERED IN PUBLIC HEALTH DEPARTMENT
 150481

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Boone

City of Coen & Boone
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

MAR 9 1925

STATISTICS

(No. 1104)

Third St.)

CERTIFICATE OF DEATH

District No. 30

Registration District No. 1051

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 48796

Local Registrar's No. 1487

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

Feb

17

1925

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day how many

hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

A. E. Mortlock

11. BIRTHPLACE

OF FATHER

(State or Country)

Canada

12. MAIDEN NAME

OF MOTHER

Margaret Williams

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Mortlock

(Address)

Coen & Boone Ida

15.

Filed

Mar. 4

1925

W. D. Drenna

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

17

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 11:15 P. M.

The CAUSE OF DEATH* was as follows:

Still Born
did not live
(no Physician)
(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. B. Drenna M. D.

2/18/25 (Address) Coen & Boone Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's

2/18 1925

20. UNDERTAKER

ADDRESS

R. B. Drenna

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

766-117-028-556
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

MAR 9 1925

BUREAU OF VITAL STATISTICS

S

County of Notenae

City of Coeur d'Alene

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. 401 Park Drive St. -

Registration District No. 30

State File No. 129486

Hospital C. D. A.

Primary Registration District No. 1051

Local Registrar's No. 1239

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate? Yes

Date of
birth 2 - 12 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

Glen Burgan Powell

RESIDENCE

401 Park Drive

COLOR

White

AGE AT LAST
BIRTHDAY

39
(Years)

BIRTHPLACE

Waitsburg, Wash.

OCCUPATION

Merchant

FULL
MAIDEN
NAME

MOTHER

Marguerite Newman

RESIDENCE

COLOR

White

AGE AT LAST
BIRTHDAY

33
(Years)

BIRTHPLACE

Spokane, Wash.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn ☒ born alive at 12:20 a M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

J. Sawyer

(Physician or midwife)

Address

Coeur d'Alene

Filed

Mar 4 1925

D. W. Drema

Registrar.

Registrar.

RECEIVED

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
OF IOWA

2

DECLASSIFICATION OF BIRTH

384231

State file No.

Local Health

NAME OF CHILD

[illegible]

1-ayo ni been saw nokiloz lablatand 14-11

Number of child of this mother included present birth

Number of child of this month - now living, including previous birth.

OTHER

444

РЕЗУЛТАТ

١٠٠

304801257

凡与国商交易时

NO. 105

AGE AT LAST
BIRTHDAY

85109

NOTA 90000

RECAPITULATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

0-98361-1

[illegible]

(471-10812)

1994-1995

2003.05.11

591.

15-00000

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Proctor*

City of *Proctor*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

MAR 9 1925

BUREAU OF VITAL STATISTICS

(No. *1051*)

Registration District No. *30*

City of *Proctor*

State of *Idaho*

Local Registrar's No. *1486*

State of IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

State File No. *48795*

Local Registrar's No. *1486*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PERSONAL AND STATISTICAL PARTICULARS

2. SEX *Male*

3. COLOR OR RACE *White*

4. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word)

5. DATE OF BIRTH *Feb 12 1925*

(Month) (Day) (Year)

6. AGE

IF LESS than 1 day how many

hrs. or

min.?

7. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

8. BIRTHPLACE

(State or Country) *Idaho*

9. NAME OF FATHER *Glen B. Powell*

10. BIRTHPLACE OF FATHER

(State or Country) *Washington*

11. MAIDEN NAME OF MOTHER *Marguerite Newman*

12. BIRTHPLACE OF MOTHER

(State or Country) *Washington*

13. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Glen B. Powell*

(Address) *Proctor Idaho*

14. Filed *Mar 4 1925*

Local Registrar *D. D. Drenna*

15. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 12 1925*

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born infant.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Drenna*

19. (Address) *Proctor Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL *Proctor*

DATE OF BURIAL *2-12 1925*

20. UNDERTAKER *R. B. Drenna*

ADDRESS *Proctor Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

636-121032-268
PLACE OF BIRTH

RECEIVED

MAR 12 1925

BUREAU OF VITAL
STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Lynch

City of Shoshone

No. _____ St. _____

Registration District No. _____

CERTIFICATE OF BIRTH

State File

129530

Hospital _____

Primary Registration District No. _____

Local Registrar's No. _____

FULL NAME OF CHILD _____

Baby: Steve Bone

(Certificate of no value without full name of child.)

Sex of
Child

Male

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

2 - 21 - 1925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? _____

None

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

FATHER
FULL
NAME

Edwards Floyd

RESIDENCE

COLOR

White

AGE AT LAST
BIRTHDAY

20

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

MOTHER
FULL
MAIDEN
NAME

Mary Johnson

RESIDENCE

Shoshone Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

20

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at _____
on the date above stated.

3 50 A

*When there was no attending physi-
cian or midwife, then the father, house-
holder, etc., should make this return.
{ A stillborn child is one that neither
breathes nor shows other evidence of
life after birth.

(Signature) _____

[Signature]

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed Feb 20

1925

[Signature]

Registrar.

Registrar.

RECEIVED

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 48818

Registered No. 1896

1. PLACE OF DEATH

County of Shoshone

City of Shoshone

(No. 106)

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

no name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Feb 20 1925

(Month)

(Day)

(Year)

7. AGE

Yrs. 30 Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

16 20 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb - 20

(Month)

(Day)

1925 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 21 1925 to Feb 21 1925

that I last saw him alive on

Born dead 1925

and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

This born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Mild heart rupture

(Duration) Yrs. mos. 20 ds.

(Signed)

M. D.

2/21 1925 (Address) Shoshone, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone

20 1925

20. UNDERTAKER

ADDRESS

O. J. Muran Shoshone

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison

City of Rifburg

No. 559-123-033-76 Subst.

Registration District No. 100

State File No.

129534

Hospital

Primary Registration District No. 2178

Local Registrar's No. 1082

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Jan. 23 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

Harper Nilson

RESIDENCE

Sugar City

COLOR

W

AGE AT LAST
BIRTHDAY

29
(Years)

BIRTHPLACE

Ida

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Sandra Goodson

RESIDENCE

Sugar City

COLOR

W

AGE AT LAST
BIRTHDAY

20
(Years)

BIRTHPLACE

Ida

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:00 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. B. Rigby M.D.

(Physician or midwife)

Address

Rifburg

Filed

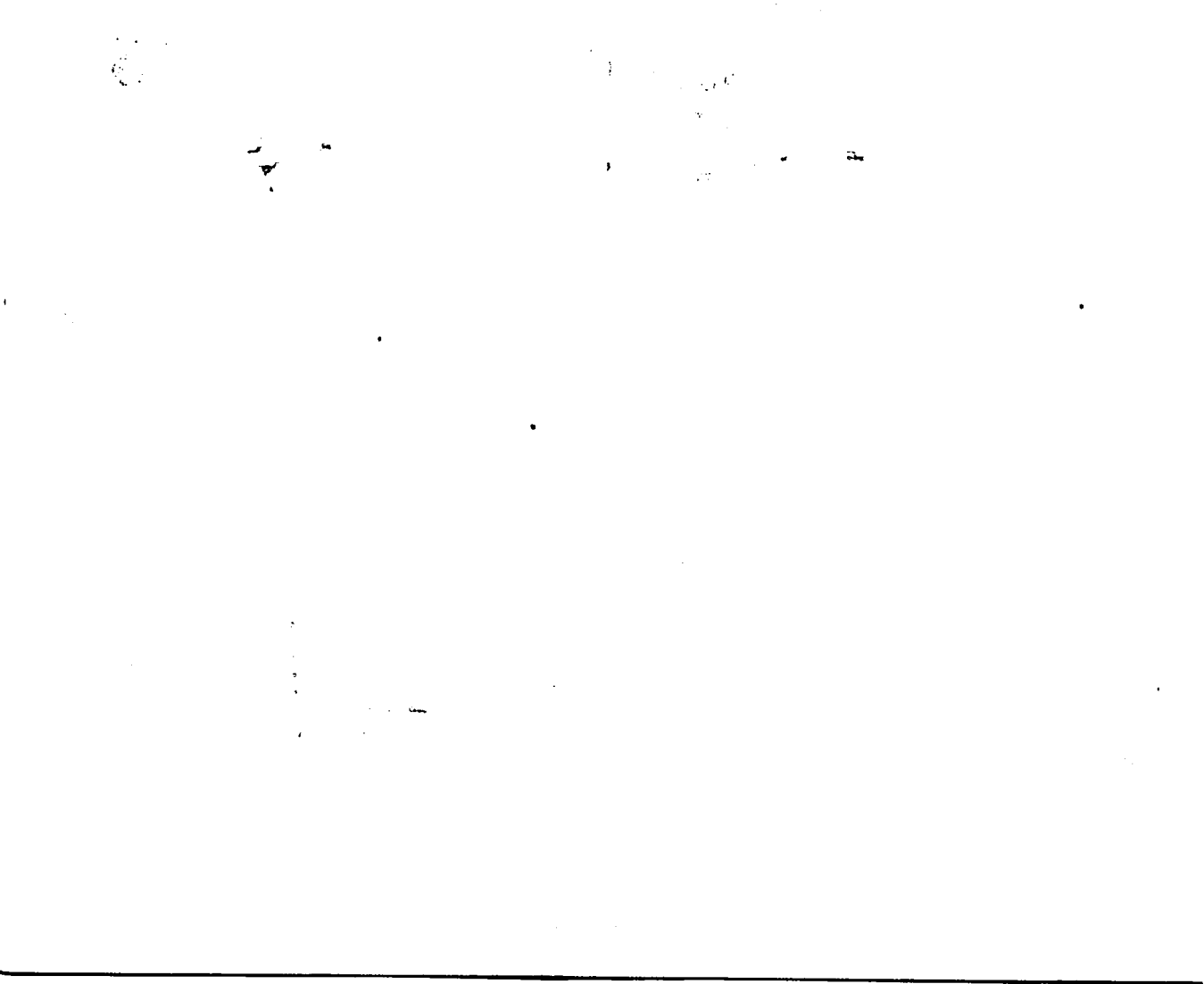
Jan 25

1925

J. R. Young

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Madison
City of Pay City

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

FEB 10 1925

BUREAU OF VITAL STATISTICS

District No. 100
Registration District No. 2178
(Pay City) St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 48824Local Registrar's No. 202

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Bale.

(Write the word)

6. DATE OF BIRTH

Jan. 23 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day how many
..... hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pay City Idaho

10. NAME OF FATHER

Hayden Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Pocatello Idaho

12. MAIDEN NAME OF MOTHER

Laura Goodson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ucon Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. J. Nielson
Pay City Idaho

15.

Filed

7/121925

J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 28 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 23 1925 to Jan 23 1925

that I last saw him alive on Jan 23 1925

and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Stillborn)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. J. Nielson M. D.2/2 1925 (Address)

*State the Disease Causing Death; or in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pay City 7/24 1925

20. UNDERTAKER

ADDRESS

J. R. Young Pay City

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of MadisonCity of ReynoldsburgNo. 866110033-867

St.

R.

S.

No.

100

State

File

No.

129550

Hospital

Primary Registration District No. 2478Local Registrar's No. 1023

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

Yes

Date of birth

Jan 10

1925

What bactericidal solution was used in eyes?

87.7 Agthos

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

5

FULL NAME

FATHER

Culbert R Howes

RESIDENCE

Reynoldsburg Newdell

COLOR

W

AGE AT LAST

BIRTHDAY

39

(Years)

BIRTHPLACE

Utah

OCCUPATION

Laborer

FULL MAIDEN NAME

MOTHER

Leah Hoggard

RESIDENCE

Reynoldsburg Newdell

COLOR

W

AGE AT LAST

BIRTHDAY

33

(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Reynoldsburg M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. B. Rigby M.D.

(Physician or midwife)

Address

Reynoldsburg

Filed

2/12

1925

J. R. Young

Registrar.

Registrar.

WHITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

345 720035-966
PLACE OF BIRTHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine **RECEIVED**
 City of Shoshone **MAR 9 1925** **CERTIFICATE OF BIRTH 129599**
 No. _____ St. _____ **BUREAU OF VITAL STATISTICS** 96 File No. _____
 Hospital Whitman Primary Registration District No. 1009 Registered No. _____
 FULL NAME OF CHILD Premature

(Certificate of no value without full name of child.)

Sex of Child Boy Twin Triplet or other? 1 } and { Number in order of birth _____ Legitimate? yes Date of birth Feb 20 1925
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... 4 ... Number of child of this mother now living, including present birth... 2 ...

FATHER
 FULL NAME August Ray Cunn
 RESIDENCE Shoshone Idaho
 COLOR White AGE AT LAST BIRTHDAY 43 (Years)
 BIRTH PLACE North Carolina
 OCCUPATION Farmer

MOTHER
 FULL MAIDEN NAME Olive Maude Rowden
 RESIDENCE Shoshone Idaho
 COLOR White AGE AT LAST BIRTHDAY 34 (Years)
 BIRTH PLACE Missouri
 OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 9 P.M.
 on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Edgar L. White M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

ShoshoneFiled Mar 6 1925 Furness E. Bruce

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
 N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each
 and the number of each, in order of birth stated.

2

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED
MAR 4 1925
BUREAU OF VITAL

CERTIFICATE OF BIRTH 129602

No. 386-228036-792 St.

Registrar District No.

26 State File No.

Hospital

Primary Registration District No.

3069 Local Registrar's No. 77

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Female } and { Number in order of birth } Legitimate? Yes } Date of birth 2-28-1925-
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 1/2000 Lysol

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Lawrence Thomas

MOTHER
FULL MAIDEN NAME Elsie Gibson

RESIDENCE Molokai

RESIDENCE Molokai

COLOR white AGE AT LAST BIRTHDAY 24 (Years)

COLOR white AGE AT LAST BIRTHDAY 19 (Years)

BIRTHPLACE Molokai

BIRTHPLACE Ind.

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (born alive) Stillborn { at 8:30 a. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. M. Kenna

(Physician or midwife)

Address

Molokai

Filed

2/28 1925 J. M. Kenna

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

217 126 042 217
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
FEB 23 1925
BUREAU OF VITAL STATISTICS

S

129669

County of Twin Falls

City of Buhl

No. _____ St. _____

Hospital _____

Registration District No. _____

Primary Registration District No. 2087

File No. _____

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <u>Yes</u> Triplet <u>No</u> or other? <u>No</u> and (Number in order of birth <u>5th</u>)	Legitimate? <u>Yes</u>	Date of birth <u>26 Jan</u> 1925 (Month) (Day) (Year)
--------------------------	--	------------------------	---

What bactericidal solution was used in eyes? Sol. neosilver 100%

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME J. E. Baxter
RESIDENCE Buhl, Idaho
COLOR White AGE AT LAST BIRTHDAY 40 (Years)

MOTHER
FULL MAIDEN NAME Elsie Baxter
RESIDENCE Buhl, Idaho
COLOR White AGE AT LAST BIRTHDAY 35 (Years)

BIRTHPLACE Kansas

BIRTHPLACE Kansas

OCCUPATION farming

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born dead at 4 A.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. W. Mac Manus

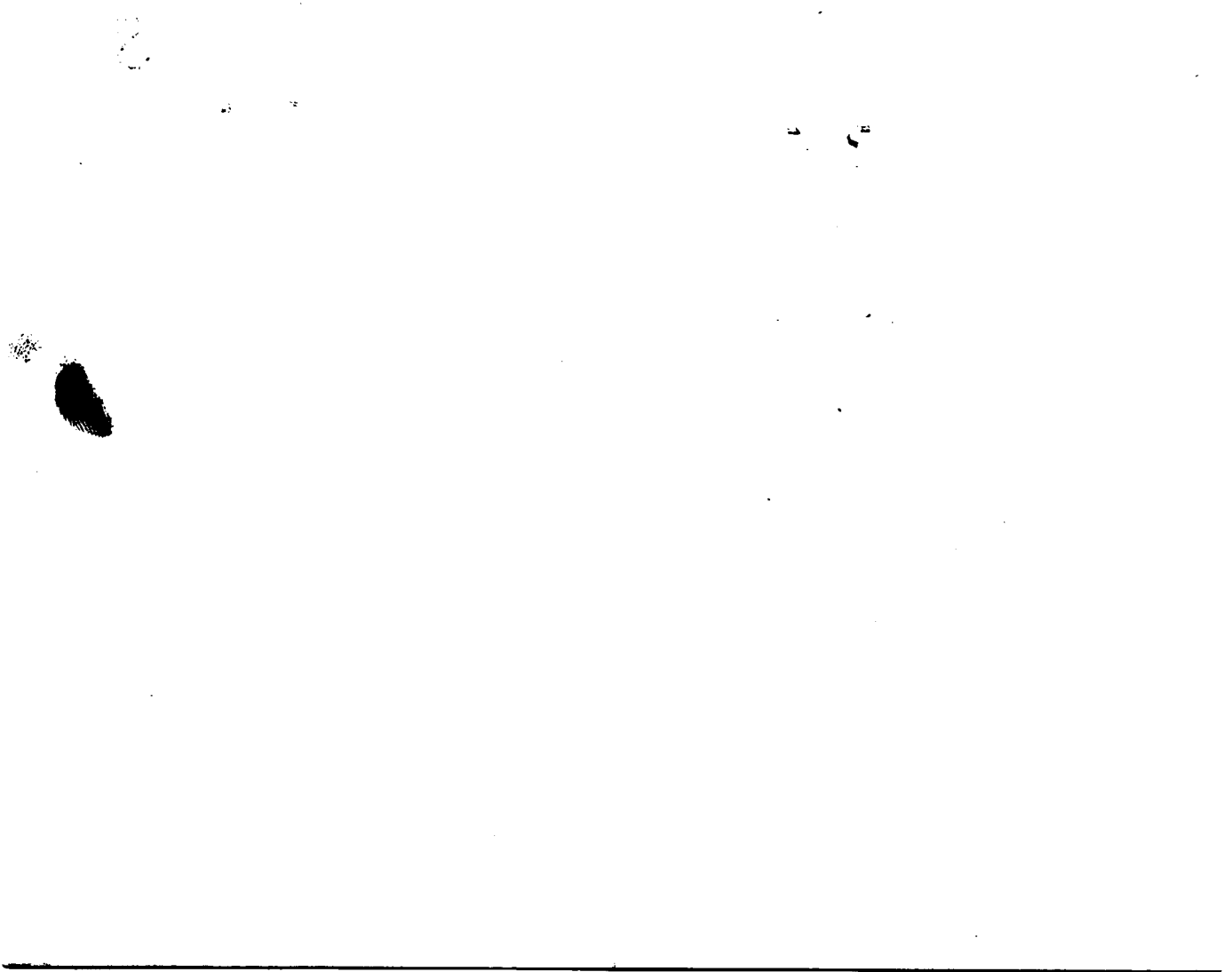
(Physician or midwife)

Give names added from a supplemental report.

Address Buhl, Idaho

Filed 1-27 1925 J. H. Murphy Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

FEB 28 1925

1. PLACE OF DEATH

County of *Boone*
City of *Bull*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Carter*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *18891*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (Married.)

6. DATE OF BIRTH

Jan 26 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).*None*

9. BIRTHPLACE

(State or Country)

Bull Idaho

10. NAME OF FATHER

Joe Carter

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Elsie Dix

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe Carter

(Address)

Bull Idaho

15.

Filed *Jan 26 1925**J. W. Weyler*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 26 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *at 4 P.M.* to *1925*that I last saw him alive on *at home* 19.....
and that death occurred on the date stated above, at *3 A.M.*

The CAUSE OF DEATH* was as follows:

poisoned with arsenic
stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. W. Weyler* M. D.19..... (Address) *Bull Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bull Cemetery *Jan 26 1925*

20. UNDERTAKER ADDRESS

Howell & Pugh *Bull Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

415 713 042 895
PLACE OF BIRTH

RECEIVED
BUREAU OF VITAL STATISTICS
JAN 14 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls
City of Twin Falls

No. _____ St. _____

District No. 37

File No. 129687

Hospital _____

Primary Registration District No. 1085

Registered No. _____

FULL NAME OF CHILD _____

Davis

(Certificate of no value without full name of child.)

Sex of Child <u>Boy</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>1/13</u> 192 <u>5</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Marcus James Davis
RESIDENCE Twin Falls
COLOR White AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Id.
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Edna Ethel Winslow
RESIDENCE Twin Falls
COLOR White AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 11:00 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

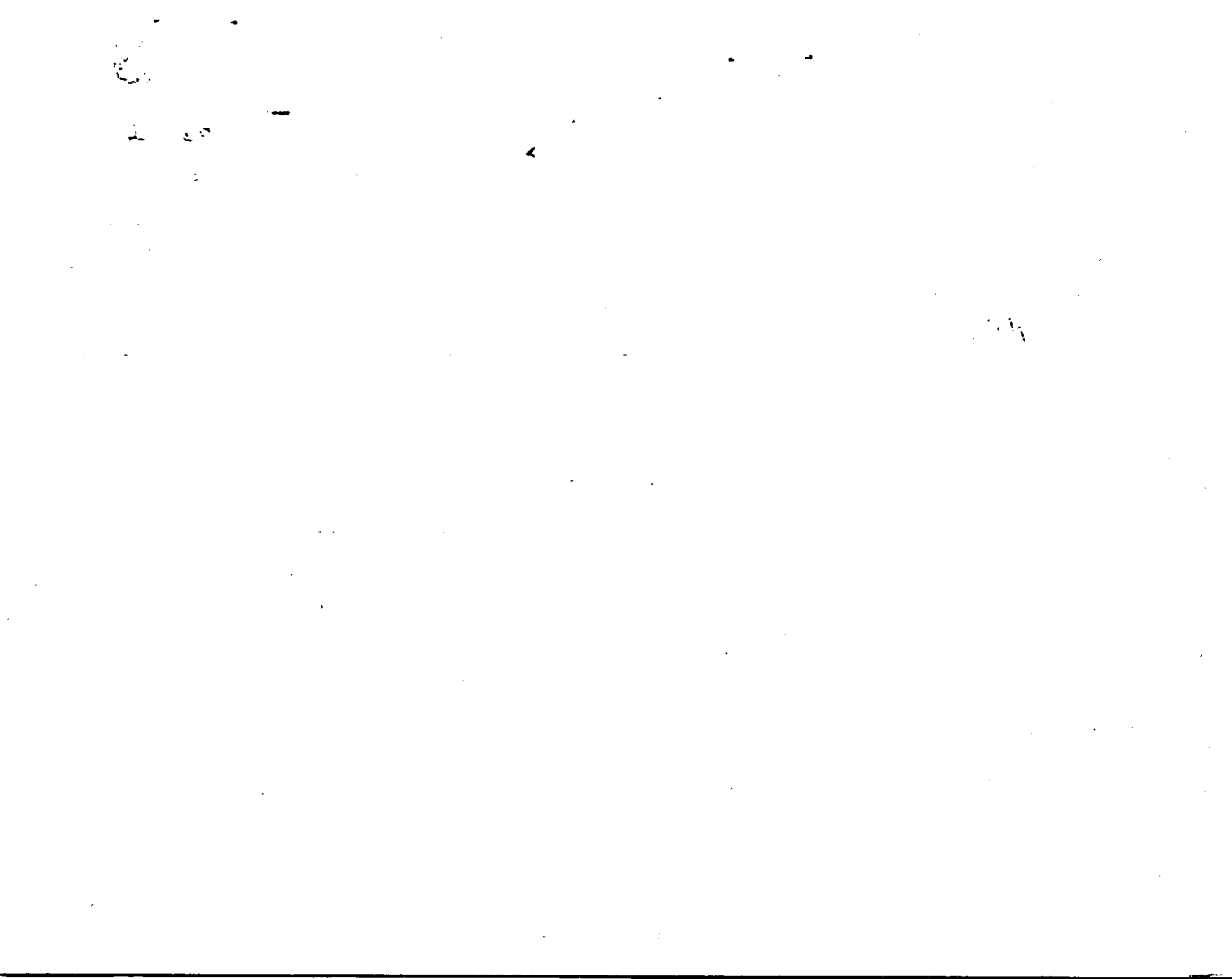
(Signature) C. D. Weaver

Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address _____
Filed Mar. 1-25 1925
John F. Coughlin
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH **RECEIVED FEB 4 1925**
Registration District No. **87**
County of **Swain Falls** Registration District No. **1085**
City of **Swain Falls** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Baby Davis**

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **48587**
Registered No. **1300**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH. **Jan 13 1925**
(Month) (Day) (Year)

7. AGE **0 Yrs. 0 Mos. 0 ds.** IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

M. Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Edna Winslowe

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

M. Davis
Swain Falls Ida

15.

Filed **Feb. 1-25**

191

John Houghkin
Local Registrar

16. DATE OF DEATH

(Month)

(Day)

(Year)

1

13

1925

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on **11/13 1925**

and that death occurred on the date stated above, at **11 A.M.**

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

G. D. Weaver M. D.

19 (Address)

Swain Falls, Ida.

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Swain Falls

1/14 1925

20. UNDERTAKER

ADDRESS

J. B. 25 with

Swain Falls

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

735-232-042-691
PLACE OF BIRTH

RECEIVED
MAR 4 1925
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

129697

County of Twin Falls

City of Twin Falls

No. P. 24 St.

Registration District No. 37

State File No.

Hospital

Primary Registration District No. 2085 Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

2 23

1925

(To be answered only in event of plural births)

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

John Glenn

RESIDENCE

Twin Falls

COLOR

W.

AGE AT LAST
BIRTHDAY

26
(Years)

BIRTHPLACE

Wn.

OCCUPATION

Locomotive Fireman

FULL
MAIDEN
NAME

MOTHER

Sylvia Frances

RESIDENCE

Twin Falls

COLOR

W.

AGE AT LAST
BIRTHDAY

25
(Years)

BIRTHPLACE

Iowa

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn live at 2 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

John F. Coughlin
P. 24

(Physician or midwife)

Address

Twin Falls, Id.

Filed

Mar. 1 1925

John F. Coughlin
Registrar.

Registrar.

GEORGE LARRY NEED A BIRTH CERTIFICATE
 not signed by him. He is 17 years of age and is now in the army. He is a white male, born in New York City, and is now in the army. He is a white male, born in New York City, and is now in the army.

PLACE OF BIRTH

County of
 City of

No.

Hospital

Full Name of Child

Sex of Child

Twin
 Triplet
 Other

and {
 of birth
 (To be answered only in case of plural birth)

Weight
 Length

Date of Birth
 (Month) (Day) (Year)

What pathological condition was used in case?

Number of child of this mother, including present birth

FATHER

NAME
 FULL
 NAME

MOTHER
 FULL
 NAME

COLOR

AGE AT LAST BIRTHDAY (Year)

COLOR

AGE AT LAST BIRTHDAY (Year)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at

When there was no attending physician or midwife then the father, husband, or mother should make the report. A statement that is one that neither physician nor midwife signed after birth. Give names added from a supplementary report.

(Signature of mother)

(Signature)

Address

Filed

192

MANHATTAN STATISTICS
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF HEALTH

CERTIFICATE OF BIRTH

150003

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

154-2000-273
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada
City of Boise
No. St. Luke St. Registration District No. 2 State File No. 129790
Hospital St. Luke Primary Registration District No. 1002 Local Registrar's No. 91
FULL NAME OF CHILD Infant Anderson

(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin Triplet or other? <u>1</u>	and	Number in order of birth <u>8</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Mar 20</u> (Month) (Day) (Year) <u>1925</u>
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? Original None

Number of child of this mother, including present birth. 8 Number of child of this mother now living, including present birth. 6

FATHER		MOTHER	
FULL NAME	<u>Amos J. Anderson</u>	FULL MAIDEN NAME	<u>Ray Hutchinson</u>
RESIDENCE	<u>Boise R.D. 4</u>	RESIDENCE	<u>R.D. 4. Boise</u>
COLOR	<u>W.</u>	COLOR	<u>W.</u>
AGE AT LAST BIRTHDAY	<u>46</u> (Years)	AGE AT LAST BIRTHDAY	<u>46</u> (Years)
BIRTHPLACE	<u>Adams Co. Idaho</u>	BIRTHPLACE	<u>Cassia Co. Idaho</u>
OCCUPATION	<u>P.C. Custodian</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at St. Luke 12:30 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) T. N. Brant

(Physician or midwife)

Address Empire Bldg. Boise

Filed 3/21/25 P. N. Pratt

Regist. 192

Regist. 91

UNOFFICIAL TRANSMITTAL ATTACHED TO THIS REPORT IS A COPY OF THE REPORT OF THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH, AS TO THE DEATH OF THE CHILD, AND IS NOT TO BE USED AS A BASIS FOR ANY OTHER ACTION.

STATE OF NEW YORK
BUREAU OF VITAL STATISTICS
DEPARTMENT OF HEALTH

County of Albany
City of Albany
No. 1000
Hospital St. Mary's
Primary Residence Albany
Local Residence Albany
State File No. 1000

FULL NAME OF CHILD John Doe
(Certificate to be value without full name of child)

Sex of Child	Age at Birth	Weight at Birth	Length at Birth	Color of Hair	Color of Eyes
Male	10	10	10	Black	Blue

What bacteriological solution was used in report None

Number of child of this mother 1, including present birth

Number of child of this mother now living, including present birth 1

FULL NAME	FATHER	MOTHER
RESIDENCE	RESIDENCE	RESIDENCE
COLOR	COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born 10/10/10 at Albany New York.

When there was no attending physician or midwife, then a doctor, nurse, holder, etc. should make this report. A physician or midwife is one that makes a medical or other official statement of the birth of a child.

Give names and dates of subsequent reports None

Address Albany
Name John Doe
Signature John Doe
Physician or Midwife

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
APR 4 1925
BUREAU OF VITAL STATISTICS

Form V. S. No. 5 20M.1-10-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH Boise Registration District No. 8
County of Boise Primary Registration District No. 2098
City of Boise (No. 28, Franklin School St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Anderson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 18921
Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Mar 20 1925
(Month) (Day) (Year)

7. AGE 1 yrs. 15 mos. 15 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION None
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Boise Idaho
(State or Country)

10. NAME OF FATHER A. J. Anderson

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Ray Hutchison

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Anderson
(Address) Rt 4 Boise Ida.

15. Filed 3/21/25 1915 R. W. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 20 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1925 to Mar 28 1925
that I last saw Still Born 1915

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Death occurred about five days before birth from toxemia
(Duration) yrs. 1 mos. 15 ds.

Contributory Toxemia of Mother
(Secondary)

(Duration) yrs. 1 mos. 15 ds.
(Signed) T. H. Grayson M. D.

Mar 1925 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

1/2 mi S Franklin School 3/21 1915

20. UNDERTAKER ADDRESS

A. J. Anderson R.O. 4

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each in order of birth stated.

PLACE OF BIRTH
122-225003-289
County of Bannock
City of Pocatello

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
MAR 14 1925 BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

No. _____ St. _____ Registration District No. 28 State File No. T29859
Hospital Poca Genl Primary Registration District No. 2161 Local Registrar's No. 6910
FULL NAME OF CHILD Baby Asbach

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and {Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>2-25-1925</u> (Month) (Day) (Year)
----------------------------	--	-------------------------------------	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FATHER FULL NAME <u>George Dow Asbach</u> RESIDENCE <u>Pocatello Idaho</u> COLOR <u>wh</u> AGE AT LAST BIRTHDAY <u>38</u> (Years) BIRTHPLACE <u>Iowa</u> OCCUPATION <u>Carpenter</u>	MOTHER FULL MAIDEN NAME <u>Pansy Thira</u> RESIDENCE <u>same</u> COLOR <u>wh</u> AGE AT LAST BIRTHDAY <u>27</u> (Years) BIRTHPLACE <u>Iowa</u> OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. C. Ray

Give names added from a supplemental report.

(Physician or midwife)
Address Pocatello Idaho

Filed 3/1 1925 Registrar W. J. Young

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Banner POCATELLO, IDAHO

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. _____

Registration District No. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. _____

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father

11. BIRTHPLACE

OF FATHER

(State or Country)

12. MAIDEN NAME

OF MOTHER

13. BIRTHPLACE

OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

28

7161

18939

4551

Infant Asbach

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 25 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____,

that I last saw h..... alive on _____ 19____,
and that death occurred on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Still born.
Deformed pelvis
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

2-27-19-25

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Int View Pocatello Feb 26 1925

20. UNDERTAKER

McHAN UNDERTAKING CO

ADDRESS

POCATELLO, IDAHO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **22 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bingham

APR 5 1925

City of Aberdeen

BUREAU OF VITAL STATISTICS
STATISTICS

No. 446-213006-789 st.

Registration District No. 116

State File No. 129882

Hospital

Primary Registration District No. 2193

Local Registrar's No. 116

FULL NAME OF CHILD

Still born - (Duffin)

(Certificate of no value without full name of child)

Sex of Child

male

Twin
Triplet
or other?

(To be answered only in event of plural births)

Number
in order
of birth

Legiti-
mate?

yes

Date of birth March 13 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth 1

FULL
MAIDEN
NAME

FATHER

Roland Henry Duffin

RESIDENCE

Aberdeen Ida

COLOR

white

AGE AT LAST

BIRTHDAY 24
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Lawyer

FULL
MAIDEN
NAME

MOTHER

Ella May Phillips

RESIDENCE

Aberdeen Ida

COLOR

white

AGE AT LAST

BIRTHDAY 23
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ☒ Born alive ☐ Stillborn at 250 A M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

McMurtre

(Physician or midwife)

Aberdeen Ida

Address

Idaho

Filed March 13 1925

Registrar.

Registrar.

THIS IS A LEGAL DOCUMENT
 ANYONE WHOSE NAME IS ON THIS DOCUMENT
 IS RESPONSIBLE FOR THE INFORMATION
 CONTAINED HEREIN

PLACE OF BIRTH

STATE OF IDAHO
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

2

CERTIFICATE OF BIRTH

158885

Registration District No. 1

Birth Registration District No. 1

Hospital

LEGAL NAME OF CHILD

(Indicate if no name without full name of child)

Sex M F
 (To be answered only in event of twinning)
 Twin
 Single
 (To be answered only in event of twinning)
 Male
 Female
 Date of Birth
 (Year) (Month) (Day)

What hospital notation was used in 1901

Name of child of this mother, including present birth

MOTHER

FATHER

NAME
 MARRIED
 UNMARRIED

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

COLOR

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at

on the date above stated.

When there was no attending physician or midwife then the date is home-born and should make this return. A newborn child is one that neither breathes nor shows other evidence of life after birth.

(Give names added from a supplemental report)

192

Notary

Address

Filed

192

Registrar

(Physician or midwife)

(Signature)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

APR 5 1925

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Abertien
Registration District No. 116
Registration District No. 2195

File No. 18341
Registered No. 18341

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born / Duffin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single

6. DATE OF BIRTH March 13 1925
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. — ds.
IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Roland H. Duffin

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Ella May Phillips

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. H. Duffin
(Address) Abertien Ida

15. Filled March 13 1925 M. C. Markum
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw h. — alive on 19 and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Still born -
Pressure of obstetrical forceps on cerebri
(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) M. C. Markum M. D.

March 13 1925 (Address) Abertien Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death? —

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL Abertien Ida DATE OF BURIAL March 14 1925

20. UNDERTAKER friends ADDRESS —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

6131277006-281
PLACE OF BIRTH

RECEIVED

APR 7 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Blackfoot

STATISTICS

CERTIFICATE OF BIRTH

No. RA# St. _____

Registration District No. 121

State File No. 129891

Hospital _____

Primary Registration District No. 2194

Local Registrar's No. 79

FULL NAME OF CHILD _____

No name Walker

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth
(To be answered only in event of plural births)

Legiti-
mate? Yes

Date of birth Mar 27 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes? argyrol

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FATHER
FULL NAME George Clifford Walker

RESIDENCE Blackfoot

COLOR White AGE AT LAST BIRTHDAY 37
(Years)

BIRTHPLACE Utah

OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Rosella Ann Sharp

RESIDENCE Blackfoot

COLOR White AGE AT LAST BIRTHDAY 28
(Years)

BIRTHPLACE Utah

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8:30 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. W. Beck

(Physician or midwife)

Address Blackfoot Idaho

Filed April 5 1925 W. W. Beck

Registrar.

Registrar.

1. PLACE OF DEATH

County of BinghamCity of Blackfoot

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME

StillbornRECEIVED
APR 7 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121Registration District No. 2194

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 18929Registered No. 137

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

March 27 1925
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Clifford Walker

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Roseella Ann Sharp

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George C. Walker

(Address)

Blackfoot, Ida. Route 1

15.

Filed

Mar 27 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 27 1925 to Mar 27 1925
that I last saw him alive on Wednesday before I arrived
and that death occurred on the date stated above, at 8 AM.

The CAUSE OF DEATH* was as follows:

Proapsed cord for about 30 minutes before I arrived.

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

W. W. Beck M. D.3/27 1925 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

George C. Walker

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
389-117 009-533
County of Bozeman
City of Sandpoint
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
APR 5 1925 CERTIFICATE OF BIRTH
BUREAU OF VITAL
Registration District No. 78 State File No. 129926

S

Hospital Page Primary Registration District No. 2155 Local Registrar's No.

FULL NAME OF CHILD Christenson
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>Feb 17</u> , 192 <u>5</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>Victor Edward Christenson</u>	FULL MAIDEN NAME	<u>Flourence Ellersick</u>
RESIDENCE	<u>Hoover, Ida.</u>	RESIDENCE	<u>Hoover, Ida.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>23</u> (Years)
BIRTHPLACE	<u>Laclede, Ida</u>	BIRTHPLACE	<u>Minnesota</u>
OCCUPATION	<u>Salesman</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ☒ Born alive ☐ Stillborn at 11:50 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. R. Evans
M. W.
(Physician or midwife)

Give names added from a supplemental report., 192....

Address Sandpoint Hoover
Filed 4-3 1925 Viola Allen
Deputy Registrar.

Registrar.

S

CERTIFICATE OF BIRTH

City of _____
 No. _____
 St. _____
 Bureau _____
 Registration District No. _____
 State File No. _____
 15935

Hospital _____
 Primary Registration District No. _____
 Local Registrar's No. _____

CHILD NAME OF CHILD

(Certificate of no value without full name of child).

Date of Birth		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Social Security Number		Other Identifying Information	
Month	Day	Year	Age	Sex	Race	Religion	Marital Status	Occupation	Education	Social Security Number	Other Identifying Information								
1	1	1900	1	M	W	C	M	W	H	1	1								
2	2	1901	2	F	B	M	M	W	H	2	2								
3	3	1902	3	M	W	C	M	W	H	3	3								
4	4	1903	4	F	B	M	M	W	H	4	4								
5	5	1904	5	M	W	C	M	W	H	5	5								
6	6	1905	6	F	B	M	M	W	H	6	6								
7	7	1906	7	M	W	C	M	W	H	7	7								
8	8	1907	8	F	B	M	M	W	H	8	8								
9	9	1908	9	M	W	C	M	W	H	9	9								
10	10	1909	10	F	B	M	M	W	H	10	10								
11	11	1910	11	M	W	C	M	W	H	11	11								
12	12	1911	12	F	B	M	M	W	H	12	12								
13	13	1912	13	M	W	C	M	W	H	13	13								
14	14	1913	14	F	B	M	M	W	H	14	14								
15	15	1914	15	M	W	C	M	W	H	15	15								
16	16	1915	16	F	B	M	M	W	H	16	16								
17	17	1916	17	M	W	C	M	W	H	17	17								
18	18	1917	18	F	B	M	M	W	H	18	18								
19	19	1918	19	M	W	C	M	W	H	19	19								
20	20	1919	20	F	B	M	M	W	H	20	20								
21	21	1920	21	M	W	C	M	W	H	21	21								
22	22	1921	22	F	B	M	M	W	H	22	22								
23	23	1922	23	M	W	C	M	W	H	23	23								
24	24	1923	24	F	B	M	M	W	H	24	24								
25	25	1924	25	M	W	C	M	W	H	25	25								
26	26	1925	26	F	B	M	M	W	H	26	26								
27	27	1926	27	M	W	C	M	W	H	27	27								
28	28	1927	28	F	B	M	M	W	H	28	28								
29	29	1928	29	M	W	C	M	W	H	29	29								
30	30	1929	30	F	B	M	M	W	H	30	30								
31	31	1930	31	M	W	C	M	W	H	31	31								
32	32	1931	32	F	B	M	M	W	H	32	32								
33	33	1932	33	M	W	C	M	W	H	33	33								
34	34	1933	34	F	B	M	M	W	H	34	34								
35	35	1934	35	M	W	C	M	W	H	35	35								
36	36	1935	36	F	B	M	M	W	H	36	36								
37	37	1936	37	M	W	C	M	W	H	37	37								
38	38	1937	38	F	B	M	M	W	H	38	38								
39	39	1938	39	M	W	C	M	W	H	39	39								
40	40	1939	40	F	B	M	M	W	H	40	40								
41	41	1940	41	M	W	C	M	W	H	41	41								
42	42	1941	4																

What bactericidal solution was used in experiment 1?

Number of child of this mother now living, including present birth

[illegible]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

1 properly certify that I attended the birth of this child, who was
born on the date above stated.

When there was no attending physician or midwife, then the father or holder, should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____
(Physician or midwife) _____

Give names added from a supplementary report.

Filed _____ 1982

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
CERTIFICATE OF DEATH
Registration District No. 78
BUREAU OF VITAL STATISTICS
Registration District No. 2155

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 48681
Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Christenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH Febry 17 1925
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day how many
_____ hrs. or
Yrs. Mos. ds. _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER V. E. Christenson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Florence Ellersick

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. Christenson
(Address) Dover, Ida.

15. Filed Feb 21 1925 Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH 189 b

16. DATE OF DEATH Febry 17 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____,
that I last saw him alive on _____ 19____,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
stillbirth due to relaxation in mother
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) M. R. Wallentin M. D.
2-21-1925 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted _____
if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Lakeview Cemetery DATE OF BURIAL Feb. 22 1925
20. UNDERTAKER L. J. Moon ADDRESS Sandpoint Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
863-209-009 365
County of Bonner

RECEIVED

APR 5 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

City of Sand Point, Idaho BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 129945

No. St. Registration District No. 78 State File No.

Hospital Primary Registration District No. 2155 Local Registrar's No.

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other?	and { Number in order of birth	Legiti- mate? Yes	Date of birth <u>March 9,</u> 192 <u>5</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Roy A. Holm
RESIDENCE Kootenai, Idaho
COLOR White AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Norway
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Thelma Gladys Tanning
RESIDENCE Kootenai, Idaho
COLOR White AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Washington
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192

(Signature) O. F. Page
M. D.
(Physician or midwife)

Address Sand Point, Idaho

Filed 4-3 1925 Viola Allen
Deputy Registrar.

Registrar.

I hereby certify that the above is a true and correct copy of the original as the same appears in the files of the Department of Health and Human Services, State of Idaho.
 E. E.

Give names noted from a hospital report
 shows also evidence of the birth
 could be one that neither parent nor
 etc. should make this return. A physician
 or midwife, however, is authorized
 When there was no attending physician
 at the time noted

I hereby certify that I attended the birth of this child, who was [Shubert] [date] [year]
 (Signature)
 Address [Sand Point, Idaho]
 (Residence or midwife)
 E. E.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 OCCUPATION [REDACTED]
 BIRTHPLACE [Washington]
 COLOR [White]
 AGE AT LAST BIRTHDAY [20]
 RESIDENCE [REDACTED]
 NAME [REDACTED]
 FULL NAME [REDACTED]

FATHER
 FULL NAME [REDACTED]
 COLOR [White]
 AGE AT LAST BIRTHDAY [20]
 RESIDENCE [REDACTED]
 NAME [REDACTED]
 FULL NAME [REDACTED]
 MOTHER
 FULL NAME [REDACTED]
 COLOR [White]
 AGE AT LAST BIRTHDAY [20]
 RESIDENCE [REDACTED]
 NAME [REDACTED]
 FULL NAME [REDACTED]

What particular condition was noted in [REDACTED]
 Number of child in this family, including present birth [REDACTED]
 Number of child in this family, including present birth [REDACTED]
 (Date of birth) (Month) (Day) (Year)
 (Date of birth) (Month) (Day) (Year)
 (Date of birth) (Month) (Day) (Year)

STATE OF IDAHO
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 BUREAU OF VITAL STATISTICS
 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonner
City of Postonai

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

RECEIVED

Registration District No. 78

BUREAU OF VITAL STATISTICS

Primary Registration District No. 2155 (St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 18965
Local Registrar's No. 18965

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

March 9, 1925
(Month) (Day) (Year)

7. AGE

StillbirthIF LESS than 1 day how many
.....hrs. or
.....Yrs.Mos.ds.min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Father

Roy A. Holm.

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Helma Torming

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Roy A. Holm
Postonai Ida.

15.

Filed March 12, 1925 Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9, 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
19... to 19...that I last saw her on 5 am. March 9, 1925,
and that death occurred on the date stated above, at 3 am.

The CAUSE OF DEATH* was as follows:

Premature birth. 6th month.
stillbirth.

(Duration)yrs.mos.ds.

Contributory Heavy work previous day
(Secondary)

(Duration)yrs.mos.ds.

(Signed) O. J. Payne M. D.March 12, 1925 (Address) Postonai Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of deathyrs.mos.days. Stateyrs.mos.ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview Cemetery Mar 12, 1925

20. UNDERTAKER

ADDRESS

L. H. Moon Postonai Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
699-11600-693		DEPARTMENT OF PUBLIC WELFARE	
County of <u>Bonneville</u>		BUREAU OF VITAL STATISTICS	
City of <u>Idaho Falls, Ida</u>		BUREAU OF VITAL STATISTICS	
No. _____		Registration District No. <u>73</u>	
Hospital <u>L.D.D.</u>		Primary Registration District No. <u>2140</u>	
FULL NAME OF CHILD <u>Thurston John Wright</u>		Local Registrar's No. <u>2A</u>	
(Certificate of no value without full name of child)			
Sex of Child <u>male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes.</u>
(To be answered only in event of plural births)		Date of birth <u>1-16</u> 192 <u>5</u>	(Month) (Day) (Year)
What bactericidal solution was used in eyes? _____			
Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>1</u>	
FATHER		MOTHER	
FULL NAME <u>Thurston Frank White</u>		FULL MAIDEN NAME <u>Wright Orlean</u>	
RESIDENCE <u>465 - 29th Egdentt, Idaho</u>		RESIDENCE <u>Same.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Morgan, Utah</u>		BIRTHPLACE <u>Idaho Falls, Ida</u>	
OCCUPATION <u>Bridge Engineer</u>		OCCUPATION <u>Housewife</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.			
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> <input checked="" type="checkbox"/> <u>Dead alive</u> <input type="checkbox"/> at <u>4:10</u> A. M. on the date above stated.			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.			
Give names added from a supplemental report. _____, 192 <u>5</u>			
_____, 192 <u>5</u>		_____, 192 <u>5</u>	
Registrar.		Registrar.	

(Signature)

(Physician or midwife)

Address

Filed

Oct 2

1925

W. J. Fennell

Registrar.

13 April 1964

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

525-125014-752
PLACE OF BIRTH

RECEIVED

APR 5 1925

BUREAU OF VITAL
STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Cam

City of Melba

No. _____ St. _____

Registration District No. _____

File No. 129999

Hospital _____

Primary Registration District No. 2006

Registered No. 56

FULL NAME OF CHILD

Clarence Eberhard

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>3-25-1925</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bacteriocidal solution was used in eyes? Yes ✓

Number of child of this mother, including present birth... 6 ... Number of child of this mother now living, including present birth... 5 ...

FULL NAME <u>Ernest Eberhard</u>	FATHER
RESIDENCE <u>Melba, Id.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>46</u> (Years)
BIRTHPLACE <u>Germany</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Rosa Eberst</u>	MOTHER
RESIDENCE <u>Melba, Id.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Germany</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was born alive, at 2:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Samuel A. Swayne

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed

Apr 2 1925

Registrar.

Registrar.

3

1. PLACE OF DEATH

County of *Franklin*City of *ampa*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
NOV 6 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

District No. *7*Registration District No. *1006*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *51058*Registered No. *163*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Mar. 25 1925
(Month) (Day) (Year)

7. AGE

✓ Yrs. *✓* Mos. *✓* ds.IF LESS than 1 day
how many *0* hrs.
or *0* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Canyon Co., Idaho

10. NAME OF FATHER

Ernest Eberhard

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Rosa Gebert

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thos. A. Eberhard

15.

Filed

Nov 4 1925 Mac Kerby

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 25 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 25 1925 to *Mar 25 1925*that I last saw him alive on *✓* *19*and that death occurred on the date stated above, at *✓* *M.*

The CAUSE OF DEATH* was as follows:

Still born - no intra-uterine gestation. Cranial Injuries.(Duration) *✓* Yrs. *✓* mos. *✓* ds.Contributory
(Secondary)(Duration) *✓* yrs. *✓* mos. *✓* ds.(Signed) *Samuel A. Swartz* D.*3-27 1925* (Address) *Nampa, Id*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *✓* yrs. *✓* mos. *✓* days. In the State *✓* yrs. *✓* mos. *✓* days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Melba Cemetery

DATE OF BURIAL

Mar. 26 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

386-103-005-386
PLACE OF BIRTH

RECEIVED

APR 2 1925

BUREAU OF VITAL
STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Caribou

City of

No. St.

Registration District No. 82

State File No.

Hospital

Primary Registration District No. 2159

Local Registrar's No. 12

FULL NAME OF CHILD Inf. Thomsen

(Certificate of no value without full name of child)

Sex of Child male

Twin
Triplet
or other?

and {

Number
in order
of birth

Legiti-
mate? yes

Date of
birth Feb. 3, 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 3

FULL
NAME

FATHER

Peter Thomsen

RESIDENCE

Soda Springs

COLOR

white

AGE AT LAST
BIRTHDAY

42

(Years)

BIRTHPLACE

Denmark

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Harriett Thomsen

RESIDENCE

Soda Springs

COLOR

white

AGE AT LAST
BIRTHDAY

32

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Signature - Cause unknown

I hereby certify that I attended the birth of this child, who was { Stillborn } at 7:50 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Russell Figue

(Physician or midwife)

Address

Soda Springs

Filed

Mar 31, 1925

Elisabeth

Registrar.

Registrar.

QUESTIONS TO BE ANSWERED BY THE REGISTRAR
 1. Was the child born in the United States?
 2. Was the child born in the State of New York?
 3. Was the child born in the County of New York?
 4. Was the child born in the City of New York?
 5. Was the child born in the Town of New York?
 6. Was the child born in the Village of New York?
 7. Was the child born in the Hamlet of New York?
 8. Was the child born in the Precinct of New York?
 9. Was the child born in the Ward of New York?
 10. Was the child born in the Block of New York?

When there was no attending physician or midwife then the father, house doctor, etc. should make this report. If no child is one that neither parent nor shows other evidence of life after birth. (Give names added from a supplemental report.)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born at _____ on the date above stated.

(Signature)

Address _____

Profession _____

OCCUPATION _____

BIRTHPLACE _____

COLOR _____

RESIDENCE _____

NAME _____

FATHER

Number of child of this mother, including present birth _____

MOTHER

Number of child of this mother now living, including present birth _____

What bacteriological solution was used in case _____

To be answered only in case of illegal birth _____

Child _____

Sex of _____

Weight _____

and _____

Number _____

Length _____

Date of _____

(Certificate of no value without full name of child)

NAME OF CHILD _____

Hospital _____

Primary Registration District No. _____

Name of Father's No. _____

No. _____

Registration District No. _____

CITY OF _____

COUNTY OF _____

STATE OF NEW YORK

APR 2 1905

DEPT. OF HEALTH

STATE OF NEW YORK

2

130051

813-103-016-2419

PLACE OF BIRTH

RECEIVED
MAR 16 1925

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

County of ClarkCity of SpencerRegistration District No. 125File No. 130045

No. _____ St.

Hospital _____

Primary Registration District No. 2203

Registered No. _____

FULL NAME OF CHILD

Bary HallSex of Child MaleTwin
Triplet
or other?
(To be answered only in event of plural births)and { Number
in order
of birth
(To be answered only in event of plural births)Legiti
mate?YesDate of
BirthFeb 3

(Month) (Day)

1925
(Year)FULL
NAME

FATHER

Elbert M HallFULL
MAIDEN
NAME

MOTHER

Lulu M Burke

RESIDENCE

Spencer Idaho

RESIDENCE

Spencer Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY43
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY37
(Years)

BIRTHPLACE

NC

BIRTHPLACE

NC

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 9Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date above stated.

Stillborn, at 10:30 P. M.
(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. Jones MD

(Physician or midwife)

Given names added from a supplemental report.

19.

Address

Filed

Feb 4 1925

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

2. 1.

1. PLACE OF DEATH

County of *Clark*City of *Spencer*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bary Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

*Feb**3**1925*

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Spencer Idaho

10. NAME OF FATHER

Elbert M Hall

11. BIRTHPLACE OF FATHER

(State or Country)

NC

12. MAIDEN NAME OF MOTHER

Lulu M Burke

13. BIRTHPLACE OF MOTHER

(State or Country)

NC

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elbert M Hall

(Address)

Spencer Idaho

15.

Filed

*Feb 4**1925**BE Jones MD*

Local Registrar

RECEIVED
MAR 18 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registered in District No. *125*Primary Residence District No. *2203*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *49009*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Feb**3**1925*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn - owing to condition of mother

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

BE Jones

M. D.

2/4/1925 (Address) *Spencer Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Spencer Idaho**2-5-1925*

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

299-101-036-331
PLACE OF BIRTH

County of Lincoln
City of Malad

RECEIVED
APR 4 1925
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. 26 State File No. 130170
Hospital 2069 Local Registrar's No. 30

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth } Legitimate? Yes Date of birth 3-1 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 6
FULL NAME FATHER Albion Briggs FULL MAIDEN NAME MOTHER Ruthia Clark
RESIDENCE Ridgely Idaho RESIDENCE Ridgely Idaho
COLOR White AGE AT LAST BIRTHDAY 43 COLOR White AGE AT LAST BIRTHDAY 36
(Years) (Years)
BIRTHPLACE Utah BIRTHPLACE Utah
OCCUPATION Farmer OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

513-036-271
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Conida
City of Malad

RECEIVED

APR 4 1925

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 26 State File No. 130176
Hospital _____ Primary Registration District No. 2664 Local Registrar's No. 36

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth 7 Legitimate? Yes Date of birth 3 / 13 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argrol

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FATHER
FULL NAME Warren William Vanderhoff
RESIDENCE Ho Chiok
COLOR White AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Cedron Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ethel Cleopha Sparks
RESIDENCE Holbrook
COLOR White AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Monument, Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ☒ Stillborn ☐ ~~born~~ at 11:20 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192_____
Registrar.

(Signature) [Signature]

(Physician or midwife)
Address Malad City Idaho
Filed 3/31 1925
J. M. Kins
Registrar.

RECEIVED
APR 4 1942
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

2

CERTIFICATE OF BIRTH
BUREAU OF VITAL STATISTICS
U.S. DEPARTMENT OF HEALTH

RECEIVED
APR 4 1942
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

Local Registrar's No. _____
Registration District No. _____
Date of Birth _____

STATE OF OHIO

(Certificate of no value without full name of child)

Full Name of Child _____
Sex _____
Date of Birth _____
Place of Birth _____
Occupation _____

Full Name of Mother _____
Full Name of Father _____
Residence _____
Color _____
Age at Last Birthday _____
Birthplace _____
Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
born on the _____ day of _____, 1942.
When there was an attending physician or midwife, I am to sign this certificate. A signature alone would make this record invalid. It is one that neither parent nor anyone other than the attending physician or midwife should sign. This is a legal record and should be kept as such.

Physician or Midwife _____
Signature _____
Date _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

386.117.032-972
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Oneida **RECEIVED**
City of Malad APR 4 1925
BUREAU OF VITAL
No. _____ St. ~~STATISTICS~~ District No. 26 State File No. _____
Hospital _____ Primary Registration District No. 2069 Local Registrar's No. 40
FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth 3-17 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 2

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Geo. E. Thompson</u>	<u>Malad, R.T.D.</u>	<u>Mary Spason</u>	<u>Malad R.T.D.</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Malad</u>		BIRTHPLACE <u>Malad</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ☒ Born alive ☐ Stillborn at 12:05 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. M. Carson

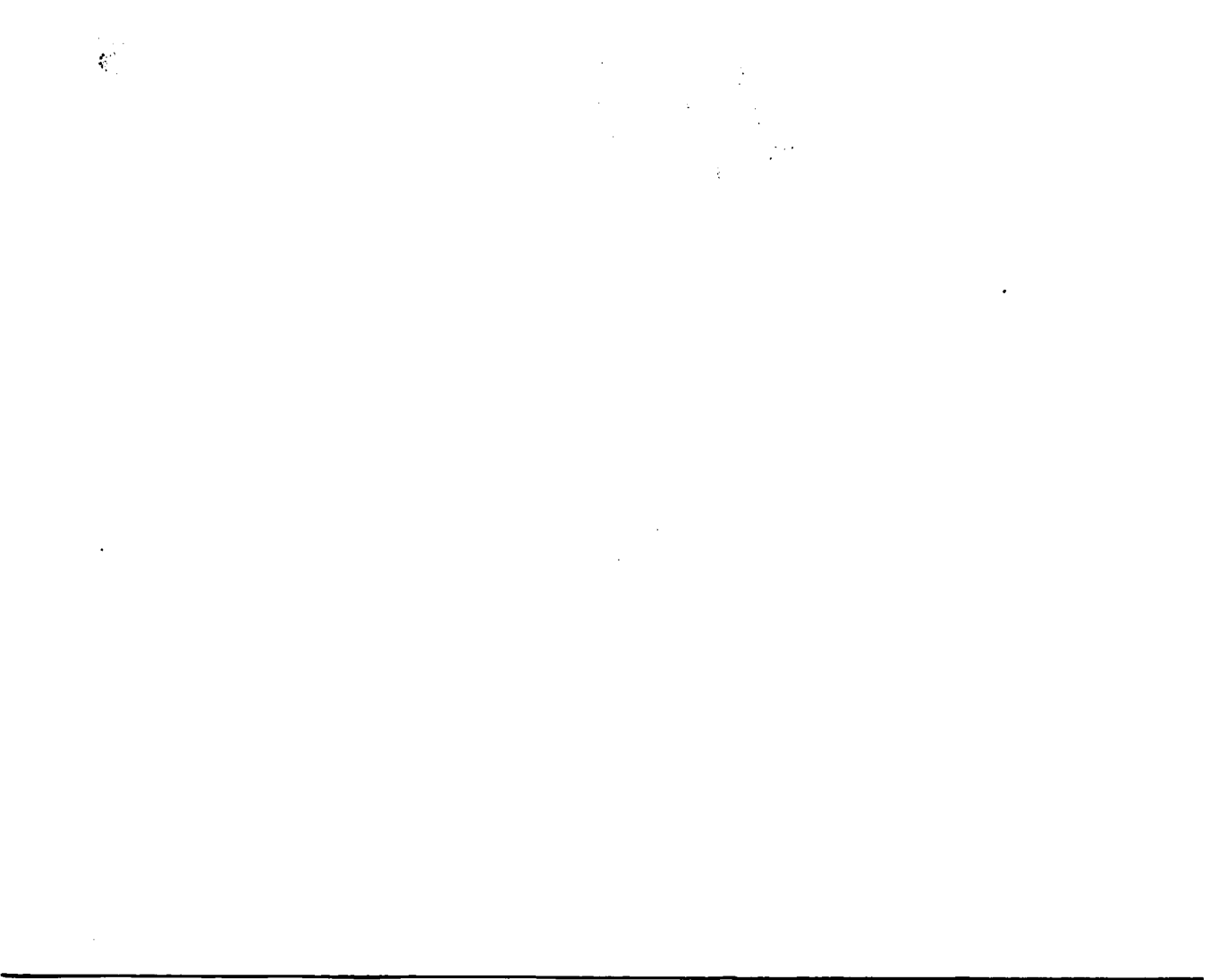
(Physician or midwife)

Address Malad, Idaho

Filed 3/31 1925

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

494-236-003-255
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED
APR 16 1925
BUREAU OF VITAL STATISTICS

County of Bonnoch
City of Pocatello
No. 33771 1st. St. Registrar's No. 28 State File No. 130347
Hospital home Primary Registration District No. 2161 Local Registrar's No. 6954
FULL NAME OF CHILD Janey Lona Derrick
(Certificate of no value without full name of child)
Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth March 31 1925
(To be answered only in event of plural births) (Month) (Day) (Year)
What bactericidal solution was used in eyes? 20 Nis Presol
Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 3
FULL NAME FATHER Geo Derrick FULL MAIDEN NAME MOTHER Jane Kellow
RESIDENCE 337 N 7th Pocatello RESIDENCE 337 N 7 Pocatello
COLOR White AGE AT LAST BIRTHDAY 37 (Years) COLOR W AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Spanish Fork, Ut. BIRTHPLACE Bingham, Ut.
OCCUPATION Cement Finisher OCCUPATION Home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn born alive at 7:40 a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. Call M.D.

(Physician or midwife)

Address Carson Bldg Pocatello

Filed 4/1 1925

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

866-120-807-293
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
MAY 5 1925
BUREAU OF VITAL STATISTICS

STATE OF IDAHO

S

County of Blaine
City of Hailey
No. _____ St. _____

CERTIFICATE OF BIRTH
Register and District No. 59 File No. _____

130442

Hospital _____ Primary Registration District No. 2022 Registered No. 31

FULL NAME OF CHILD

Baby Hawes

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <input checked="" type="checkbox"/> Yes } and { Number in order of birth <u>1</u> Triplet or other? (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>4 20 1925</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bactericidal solution was used in eyes? Ag. No. 3

Number of child of this mother, including present birth... 2 Number of child of this mother now living, including present birth... 2

FATHER		MOTHER	
FULL NAME <u>David J. Hawes</u>	FULL MAIDEN NAME <u>Marie S. Kiker</u>	FULL NAME <u>Marie S. Kiker</u>	FULL MAIDEN NAME <u>Marie S. Kiker</u>
RESIDENCE <u>Hailey, Ida</u>	RESIDENCE <u>Hailey, Ida</u>	RESIDENCE <u>Hailey, Ida</u>	RESIDENCE <u>Hailey, Ida</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)
BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Ida</u>	BIRTHPLACE <u>Ida</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING ☒ PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6:30 9 M.
on the date above stated. (Born alive or stillborn)

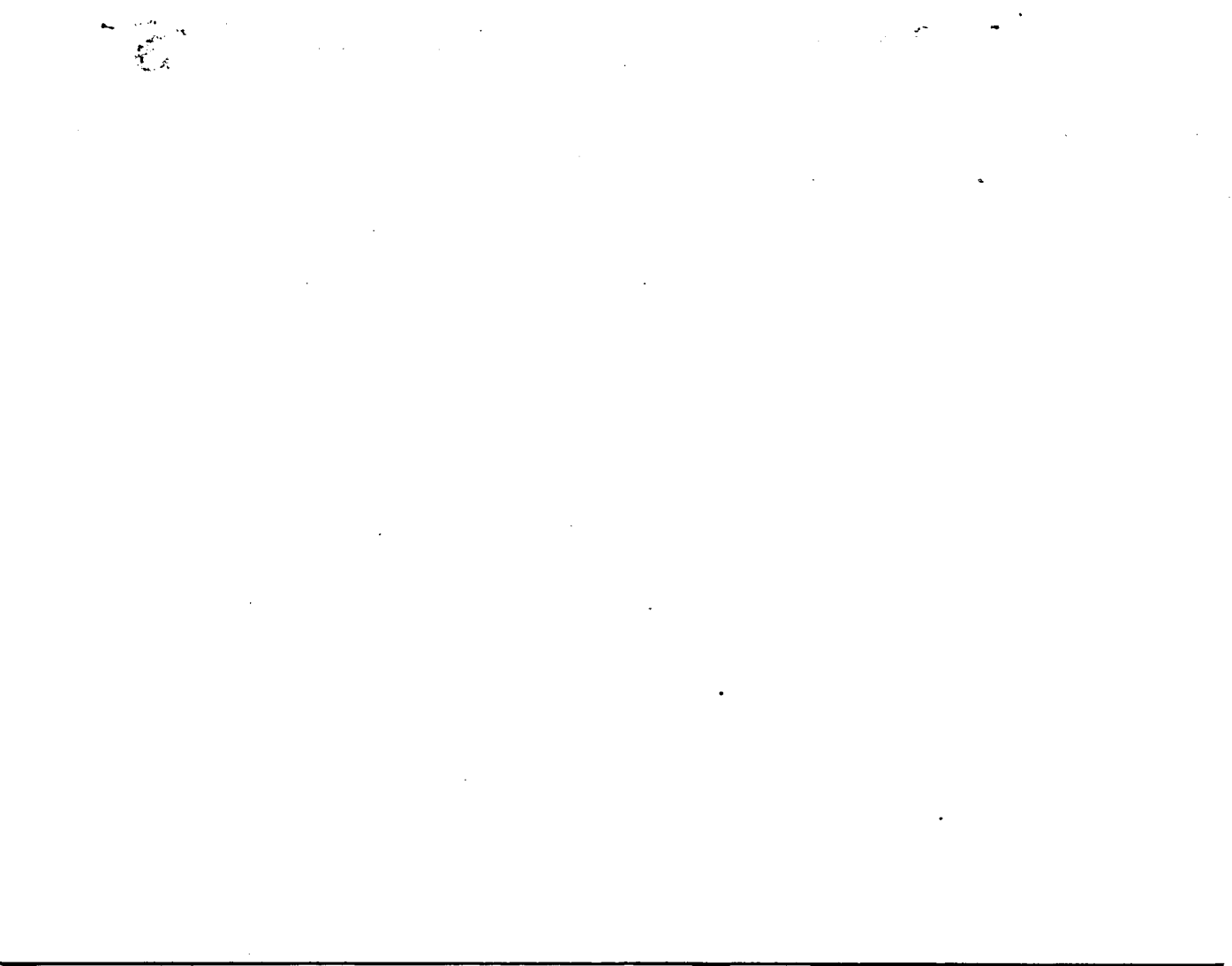
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Robert H. Wright, M.D.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Hailey, Ida
Filed 4-25 1925 Robert H. Wright
Registrar



1. PLACE OF DEATH

County of Blaine
City of Hailey

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 5
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 57Primary Registration District No. 2022State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 49174Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Howes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

April 20 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Hailey, Idaho.

10. NAME OF FATHER

D. J. Howes.

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa.

12. MAIDEN NAME OF MOTHER

May L. Kilker.

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D. J. Howes.
Hailey, Idaho.

15.

Filed

5-11925R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Winter;April 20 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born 8 months

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Robert H. Wright M. D.
4/21/1925 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey, Ida.April 20 1925

20. UNDERTAKER

ADDRESS

J. Harris.Hailey

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

866-120-007-293
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine

MAY 5 1925

CERTIFICATE OF BIRTH

130443

City of HaileyBUREAU OF VITAL
STATISTICSRegistration District No. 57

File No. _____

No. _____ St. _____

Hospital _____

Primary Registration District No. 2022Registered No. 32

FULL NAME OF CHILD

Baby Homes

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <input checked="" type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/>	and	Number in order of birth <u>2nd</u>	Legitimate? <u>Yes</u>	Date of birth <u>4 20 1925</u> (Month) (Day) (Year)
--------------------------	--	-----	-------------------------------------	------------------------	--

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? 29 No 3Number of child of this mother, including present birth 4Number of child of this mother now living, including present birth 2FULL NAME FATHER David J. HomesFULL MAIDEN NAME MOTHER Marie S. KikerRESIDENCE Hailey, IdaRESIDENCE Hailey, IdaCOLOR White AGE AT LAST BIRTHDAY 42
(Years)COLOR White AGE AT LAST BIRTHDAY 43
(Years)BIRTHPLACE IowaBIRTHPLACE Ida.OCCUPATION FarmerOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated.

Stillborn at 16:45 M.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Robert H. Wright-Mos

(Physician or midwife)

Give names added from a supplemental report.

Address Hailey, Ida
Filed 4-25 1925 Robert H. Wright
Registrar

UNION PACIFIC AGENCIES AGENCIES THE SINGAPORE HIR Y INIAZ RUM
 1. The following information is given in this report in relation to the child in question and the
 2. The following information is given in this report in relation to the child in question and the

130443

STATE OF NEW YORK
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of _____
 City of _____
 No. _____
 Registered District No. _____
 Birth No. _____
 Registered No. _____
 Primary Registration District No. _____
 Registered No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child)
 Sex of Child _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____
 (Year) _____

What particular information was used in case?
 Number of child of this mother, including present birth _____
 Number of child of this mother, even when including present birth _____

FATHER		MOTHER	
NAME	NAME	NAME	NAME
RESIDENCE	RESIDENCE	RESIDENCE	RESIDENCE
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION	OCCUPATION	OCCUPATION
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
COLOR	COLOR	COLOR	COLOR

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 on the date stated _____
 (Signature) _____
 (Address of the birth) _____

Give names added from a supplemental report _____
 Address _____
 Filed _____
 Registered _____

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

STATIST

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn 8 months

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4-21-1925

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

18
22
24
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98
100

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

862-119-01X-11 3
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Canyon

MAY 5 1925

City of Nampa

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

130551

No. _____ St. _____

Registration District No. 7

State File No. _____

Hospital Masey

Primary Registration District No. 1006

Local Registrar's No. 53

FULL NAME OF CHILD No name

(Certificate of no value without full name of child)

Sex of Child

Boy

Twin
Triplet
or other? X

and { Number
in order
of birth X

Legiti-
mate? Yes

Date of
birth April 19

(Month)

(Day)

(Year) 1925

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

George H. Hoke

RESIDENCE

Nampa Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

35

(Years)

BIRTHPLACE

Mo.

OCCUPATION

Truck driver

FULL
MAIDEN
NAME

MOTHER

Grace M. Masey

RESIDENCE

Nampa Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

32

(Years)

BIRTHPLACE

Oregon

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10¹⁵ P M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. H. Murray

(Physician or midwife)

Address Nampa Idaho

Filed Apr 30 1925

Registrar.

Registrar.

DATE OF BIRTH OF CHILD
 DATE OF DEATH OF CHILD
 DATE OF BIRTH OF MOTHER
 DATE OF DEATH OF MOTHER
 DATE OF BIRTH OF FATHER
 DATE OF DEATH OF FATHER

CERTIFICATE OF BIRTH

County of _____ State of _____

Registration District No. _____

Local Registrar's No. _____

(Certificate of no father or mother (in name of child))

Sex of child _____ Date of birth _____

Place of birth _____

Number of child in this mother's family including present birth _____

MOTHER FULL NAME _____

RESIDENCE _____

COLOR _____ AGE AT LAST BIRTHDAY _____

BIRTHPLACE _____

OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born _____

(Signature) _____

(Physician or midwife)

Address _____

Filed _____

1924

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

RECEIVED

County of Blaine

Registration District No. 7

City of Nampa

Primary Registration District No. 1906

State File No. 49220

Local Registrar's No. 100

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of Geo. H. Hoke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

April 19 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

1 Yrs. 1 Mos. 1 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Geo. H. Hoke

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Grose A. Macy

13. BIRTHPLACE OF MOTHER

(State or Country) Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. H. Hoke

(Address)

515 - 15th St Nampa

15.

Filed

May 4

1925

M. A. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 19 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth 19 to 4/19 1925

that I last saw him at home 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Albuminuria - also mother had "Flue" 3 weeks before - delivered at 8 months
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. P. Murray M. D.

4/19 1925 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Baker Ore

DATE OF BURIAL

4-21 1925

20. UNDERTAKER

A. H. Robinson

ADDRESS

Nampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

238-119221-789
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin

City of Muston Idaho

No. _____ St. _____

RECEIVED
BUREAU OF VITAL
STATISTICS

APR 9 1925 CERTIFICATE OF BIRTH

130628

Registration District No. 27 State File No. _____

Hospital _____ Primary Registration District No. 2119 Local Registrar's No. 44

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth <u>12</u>	Legiti- mate? <u>yes</u>	Date of birth <u>9 / 19</u> 192 <u>5</u> (Month) (Day) (Year)
--------------------------	---	--	-----------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 12 Number of child of this mother now living, including present birth 11

FATHER	
FULL NAME <u>Easmus Schronenfeldt</u>	
RESIDENCE <u>Muston Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Farmer</u>	

MOTHER	
FULL MAIDEN NAME <u>May Phillips</u>	
RESIDENCE <u>Muston Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>45</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>House Keeper</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was female at 9 30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Thos B Holder
Physician
(Physician or midwife)

Address Muston Idaho

Filed Apr. 2 1925 A. R. Cullen
Registrar.

Registrar.

RECEIVED
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 1925
 130658

PLATE OF
 COUNTY OF
 CITY OF
 No.
 Primary Registration District No.
 State File No.

FULL NAME OF CHILD
 Sex of
 Date of birth
 (Month) (Day) (Year)
 Local
 Number
 (To be answered only in case of plural births)

Was obstetrical solution was used in case?
 Number of child at this mother, including present birth
 Number of child of this mother, including previous birth

FATHER	MOTHER
FULL NAME	FULL NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
AGE AT LAST BIRTHDAY (Year)	AGE AT LAST BIRTHDAY (Year)
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was
 on the date above stated.

When there was no attending physician or midwife, then the father, non-attending, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
 Give names added from a supplemental report.
 1925
 Registrar

RECEIVED

APR 9 1925

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Franklin*
City of *Muston Idaho*BUREAU OF VITAL
STATISTICSRegistration District No. *27*
Statistical District No. *2119*
(No. St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *19244*
Registered No. *21*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

march 19 1925
(Month) (Day) (Year)

7. AGE

still Barred
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. *✓*

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Muston Idaho*

10. NAME OF FATHER

Benjamin Schrammelt

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

May Phillips

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. Schrammelt*(Address) *Muston Idaho*

15.

Filed *Apr 2 1925*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

still Birth
march 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*still born child known
only cause for death at
Birth*

(Duration) Yrs. mos. ds.

Contributory *eight months gestation*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Thos B Holder* M. D.*3/19/25* (Address) *Muston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Weston Cemetery

DATE OF BURIAL

Mar. 19 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

35-126-025-693

PLACE OF BIRTH Idaho

County of Idaho

City of Cottonwood

No. St. Registration District No. 10.5 State File No.

Hospital Primary Registration District No. 2183 Local Registrar's No. 23

FULL NAME OF CHILD Still Birth ✓

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Mar 26 1925</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>10</u>	Number of child of this mother now living, including present birth <u>4</u>
---	---

FATHER	MOTHER
FULL NAME <u>C. N. Bledsoe</u>	FULL MAIDEN NAME <u>Ida Williams</u>
RESIDENCE <u>Cottonwood, Ida.</u>	RESIDENCE <u>Cottonwood, Ida.</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>45</u> (Years)	AGE AT LAST BIRTHDAY <u>43</u> (Years)
BIRTHPLACE <u>N. Carolina</u>	BIRTHPLACE <u>N. Carolina</u>
OCCUPATION <u>School Janitor</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 192...

(Signature) Wesley Orr M.D.

(Physician or midwife)

Address Cottonwood, Idaho

Filed Apr 6 1925 W. F. Orr per 9.13

Registrar. Registrar.

THE NEW YORK TIMES
WEDNESDAY, JANUARY 19, 1893.

*When there was no attending physician or relative than the latter householder should make this report. A physician is one that neither brother nor show other evidence of life after death.

I hereby certify that I attended the birth of _____ on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at St. Albans on 11/11/1911 at 11/11/11 hours of the day of the month of 11 in the year of 1911.

(ទី ១៧៣១៩២)

(Physician or midwife)

58971A

1. **deft**

RECEIVED

OCCUPATION

ВОЛНЕНИЕ

0208

AGE AT LAST
BIRTHDAY

30A19HT918

0201

YACHTING

4409
33414

RENTAL

4113

OTHER

Whom is child of the mother, including breast-feeding

Number of child of this mother now living including present birth

(To be answered only in case of direct births)

111293
1988

0434036

10. 9. 1940

OTHER TO BEAN LINE

Certificate of no value without full name of child

Interpol

Primarily Registration District No. 2 (Los Angeles)

1994

Registration District No. State and No.

30 v19

100-111111-101

SECRET

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

14-00000

CERTIFICATE OF DEATH

49249

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of CottonwoodRegistration District No. 105
City of Cottonwood District No. 2183File No. 2
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still Birth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

March 26 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. N. Bledsoe

11. BIRTHPLACE OF FATHER

(State or Country)

N. Carolina

12. MOTHER NAME OF MOTHER

Ida Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. N. Bledsoe
Cottonwood, Ida

15.

Filed

Apr. 6 1925H. F. Orr Reg.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 26 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw h. — alive on 191and that death occurred on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:

Uremia following 7
months' still birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Wesley Orr

M. D.

3-27-1925 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood, Ida.3-27-1925

20. UNDERTAKER

ADDRESS

J. N. Bledsoe Cottonwood, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

819-2-23-238-237
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

S

County of Kootenai

MAY 6 1925

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Coeur d'Alene

BUREAU OF VITAL STATISTICS

130668

No. 812 St. B.

Registration District No. 30

State File No. 1051

Hospital ✓

Primary Registration District No. 1051

Local Registrar's No. 1051

FULL NAME OF CHILD Ethel Rae Harris

(Certificate of no value without full name of child)

Sex of Child Female

Twin Triplet or other? one and { Number in order of birth one }
(To be answered only in event of plural births)

Legitimate? yes

Date of birth April 3 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes? Neo Silsol

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 3

FULL NAME FATHER William H. Harris Jr.

RESIDENCE Coeur d'Alene

COLOR white AGE AT LAST BIRTHDAY 30
(Years)

BIRTHPLACE Minnesota

OCCUPATION Mil Sawyer

FULL MAIDEN NAME MOTHER Ethel Heathershaw

RESIDENCE Coeur d'Alene

COLOR white AGE AT LAST BIRTHDAY 31
(Years)

BIRTHPLACE Iowa

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born alive ✓ Stillborn at 4 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. H. Holden
Physician
(Physician or midwife)

Address Coeur d'Alene Idaho

Filed MAY 4 1925

D. D. DRENNAN, M. D.
Registrar.

Registrar.

OFFICE 210 HARDING BLOCK
COEUR D'ALENE, IDAHO

RECEIVED MAY 10 1968

On 12/12/1947, the following information was received from the Bureau of the Census, Washington, D. C.:

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

in 1961, I attended the birth of this child, who was

(974140328)

MEMORANDUM TO MR. BELMONT

Page 10 of 10

10-10-68

15-181209

SECTION

33A.2957918

RECEIVED

YACHTS

30A19HTHE

NO. 100

WASH DC

REFERENCE

NAME
MIDDLE
LAST

ЯЗНТОМ

Number of child of this mother now living: _____

2016年12月25日

SECRET

1. The first of these is the fact that the majority of the population of the United States is now living in urban areas. This is a result of the process of urbanization, which has been going on since the beginning of the 20th century. The population of the United States has increased from about 100 million in 1900 to over 200 million in 1960. At the same time, the population of rural areas has decreased from about 100 million in 1900 to about 50 million in 1960. This has led to a concentration of the population in urban areas, which has had a number of important consequences for the development of the United States.

7-07 - Bureau New Orleans Interoffice Mail

(signed) [illegible] since it was impossible to do so.

**Winged
Tern**

to staff
... staff
... staff

(It is advisable to use a separate file for each subject.)

Trinity Registration District No. 1

Registration Number No. State File No.

IS A RESULT OF A LACK OF RESULTS

CHART TO STATE

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

363-208-028-813
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

MAY 6 1925

CERTIFICATE OF BIRTH

130674

County of Kootenai

City of C. H. A.

No. 1111 Sherman St.

BUREAU OF VITAL
STATISTICS

Registration District No. 30 State File No.

Hospital C. H. A.

Primary Registration District No. 1051 Local Registrar's No. 1252

FULL NAME OF CHILD Theola Beth Colborn

(Certificate of no value without full name of child)

Sex of
Child

F.

Twin
Triplet
or other?

} and {

Number
in order
of birth

1

Legiti-
mate?

yes

Date of
birth

4

4

1925

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Frank P. Colborn

RESIDENCE

C. H. A.

COLOR

White

AGE AT LAST

BIRTHDAY

28
(Years)

BIRTHPLACE

Kentucky

OCCUPATION

R.R. Switchman

FULL
MAIDEN
NAME

MOTHER

Theola Hale

RESIDENCE

C. H. A.

COLOR

White

AGE AT LAST

BIRTHDAY

26
(Years)

BIRTHPLACE

Marysville Ida.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 9 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Dr Sturges

(Physician or midwife)

Address

Cooper & Coe, Ida.

Filed

5/4

1925

N. W. Swann

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

1. PLACE OF DEATH

County of *Kootenai* District No. *30*
City of *Coeur d'Alene* Registration District No. *1051*
(No. *1111* - *Sherman* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theola Ruth Colburn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *49816*
Local Registrar's No. *1516*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word)

6. DATE OF BIRTH

4 - 4 - 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Frank Colburn

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Theola Hale

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph A. Hale
Coeur d'Alene, Ida

15.

Filed *JUN 4 1925*

19

D. D. DRENNAN, M. D.
LOCAL REGISTRAR

OFFICE 210 N. 1ST ST.
COEUR D'ALENE, IDAHO

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 4 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still Born

Been dead 2 or 3 days

(Duration) yrs. mos. ds.

Contributory (Secondary)

Chemic poisoning

(Duration) yrs. mos. ds.

(Signed)

J. H. Sturges M. D.
4/5 1925 (Address) *Coeur d'Alene, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem. Coeur d'Alene *4-6 1925*

20. UNDERTAKER

ADDRESS

Carstedt *Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

693-119-029-493
PLACE OF BIRTH

RECEIVED

APR 7 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

BUREAU OF VITAL CERTIFICATE OF BIRTH
STATISTICS

130737

County of Blasak
City of Jefferson
No. _____ St. _____

Registration District No. 101

File No. _____

Hospital _____

Primary Registration District No. 2141

Registered No. 25

FULL NAME OF CHILD Armin

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>March 19</u> 192 <u>5</u> (Month) (Day) (Year)
--------------------------	--	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 7

FULL NAME <u>Albert Dodge Milcox</u>	FATHER
RESIDENCE <u>Latah County Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>54</u> (Years)
BIRTHPLACE <u>Missouri</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Ellie Gertrude Helms</u>	MOTHER
RESIDENCE <u>Latah County Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>46</u> (Years)
BIRTHPLACE <u>Iowa</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 11:05 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, or should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) P. E. Kiesel

Give names added from a supplemental report.

Address Garfield Mch

Filed Mch 25 1925 W. H. Carithers

Registrar.

Registrar.

2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH.

County of Batah

City of Garfield Wash

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 2141

BUREAU OF VITAL STATISTICS

(St.)

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 49276

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH.

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Mcw 19 1925
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida-

10. NAME OF FATHER

Albert Dodge Nilcox

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Nellie Gertrude Discus

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. D. Nilcox
(Address) Garfield Wash

15.

Filed Mcw 25 1925 M. H. Carithers
Local Registrar

16. DATE OF DEATH

Mcw 19 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____
that I last saw h. _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) P. E. Wiesel M. D.
3-20 1925 (Address) Garfield Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boofax-Wash Mcw 20 1925

20. UNDERTAKER

ADDRESS

Vione

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

255-208-036-693
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

130802

County of Oneida MAY 4 1925
City of Malad BUREAU OF VITAL STATISTICS
No. _____ St. Registration District No. 26 State File No. _____
Hospital _____ Primary Registration District No. 2069 Local Registrar's No. 52
FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth April 8 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 29763

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 6

FATHER
FULL NAME Jessie James Kent
RESIDENCE Malad
COLOR White AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Malad Ida.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Flossie Wilson
RESIDENCE Malad
COLOR White AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Ogden Utah.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Non-live { Stillborn } at 9:30 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) V. Phanst.

(Physician or midwife)

Address Malad, Ida.

Filed 4/30 1925 - J. M. Harris

Registrar.

Registrar.

I hereby certify that I attended the birth of this
 child on the date above stated.
 When there was no attending physician
 or midwife then the father, householder
 or someone named this record. A child
 born in one day without previous labor
 shows other evidence of life than birth.
 The names added form a permanent record.

CERTIFICATE OF ATTENDANCE

OCCUPATION
 BIRTHPLACE
 COLOR
 AGE AT LAST
 BIRTHDAY

RESIDENCE

NAME
 FULL
 BATHER

Number of days of this mother, including present birth

What bactericidal solution was used in eyes?

(To be answered only in case of birth)

of others
 of mother
 and
 of others

(Certified)

(Hospital)

Primary Registration

No.

State Registration Division

No.

STATE OF OHIO

*When there was no attendance observed
of military then the return A still
etc. showing that the return A still
held in one of the other divisions
showed that the return A still
held in one of the other divisions

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child who was born

1-2-9-10 (mirrored)

1927

1. PLACE OF DEATH

County of *Oneida*City of *Malad*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No.

MAY 4 1925

Primary Registration District No. *2069*

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *49315*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*single*
(Write the word.)

6. DATE OF BIRTH

April 8, 1925
(Month) (Day) (Year)

7. AGE

still born
Yrs. Mos. da.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Oneida Co., Ida.*

10. NAME OF FATHER

Jessie James Kent

11. BIRTHPLACE OF FATHER

(State or Country) *Malad Co., Ida.*

12. MAIDEN NAME OF MOTHER

Flossie Wilson

13. BIRTHPLACE OF MOTHER

(State or Country) *Malad Co., Ida.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jessie Kent*(Address) *Malad Co., Ida.*

15.

Filed *4/30* 19 *25* *J. M. Kerns*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Born Apr 8, 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Still born, 6 1/2 mos.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *V. P. Gant**Apr 8, 1925* (Address) *Malad Co., Ida.*

*State the Disease Causing Death; or in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. John's, Malad

DATE OF BURIAL

Apr. 8, 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc.; when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

8/5-201-039-239
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

APR 8 1925

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Power

City of Am. Falls

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 25 State File No. 130848

Hospital Bethany Academy Primary Registration District No. 2072 Local Registrar's No. 742

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

2nd

Legiti-
mate?

yes

Date of
birth

3 1 1925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Joseph Hareback

RESIDENCE

Roy

COLOR

white

AGE AT LAST
BIRTHDAY

37
(Years)

BIRTHPLACE

Miss

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Lizzie Scrimsher

RESIDENCE

Roy

COLOR

white

AGE AT LAST
BIRTHDAY

39
(Years)

BIRTHPLACE

Mo

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6:30 a. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. G. Logan

Physician

(Physician or midwife)

Address

Am. Falls, Ida.

Filed 4-6

1925

James Nott

Registrar.

Registrar.

THIS IS A COPY OF THE ORIGINAL RECORD OF THE BIRTH OF THE CHILD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR.

2

RECEIVED
BUREAU OF VITAL STATISTICS
APR 8 1922

BUREAU OF VITAL STATISTICS

STATISTICS

No. of Registration District No. 81

Primary Registration District No. 100

Local Registration No. 100

(Certificate of no living without full name of child)

(This answer only is case of plural births)

What pathological condition was used in case?

Number of child of this mother now living, including present birth

Number of child of this mother, including present birth

MOTHER

FATHER

NAME
MAIDEN
NAME

NAME
MAIDEN
NAME

RESIDENCE

RESIDENCE

AGE AT LAST
BIRTHDAY

COLOR

AGE AT LAST
BIRTHDAY

COLOR

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at

on the day stated. I hereby certify that I attended the birth of this child, who was born at

(Physician or midwife)

Address

Filed

Registrar

RECEIVED

FORM V. S. No. 5-25 M. 1-16-

APR 8 1925

CERTIFICATE OF DEATH.

1. PLACE OF DEATH **BUREAU OF VITAL STATISTICS** District No. 25
 County of Down Primary Registration District No. 2072
 City of Am-falls (No. Britany Infant St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Bavelacock

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 49335

Registered No. 236

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH. 3 / 1 / 1925
 (Month) (Day) (Year)

7. AGE stillborn IF LESS than 1 day
 how many hrs. or
 min. stillborn
 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J. H. Bavelacock

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Lizzie Scrimsher

13. BIRTHPLACE OF MOTHER

(State or Country) Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 / 1 / 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw him alive on 191
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) V. G. Logau M. D.

19 (Address) Am-falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rockland Id. Mar. 2 - 1925

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

364-210-039-132
PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Power

City of Am. Falls

No. _____ St. _____

APR 8 1925
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

Registration No. _____ State File No. 130850

Hospital Bethany Deaconess Primary Registration District No. 2172 Local Registrar's No. 744

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>3-10-</u> 192 <u>5</u> (Month) (Day) (Year)
----------------------------	--	-----------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME <u>Roele Compton</u>	FATHER
RESIDENCE <u>Am. Falls</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>Washington</u>	
OCCUPATION <u>Grain clerk</u>	

FULL MAIDEN NAME <u>Myrtle Alberts</u>	MOTHER
RESIDENCE <u>Am. Falls</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 9:20 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

V. B. Logan
Physician
(Physician or midwife)

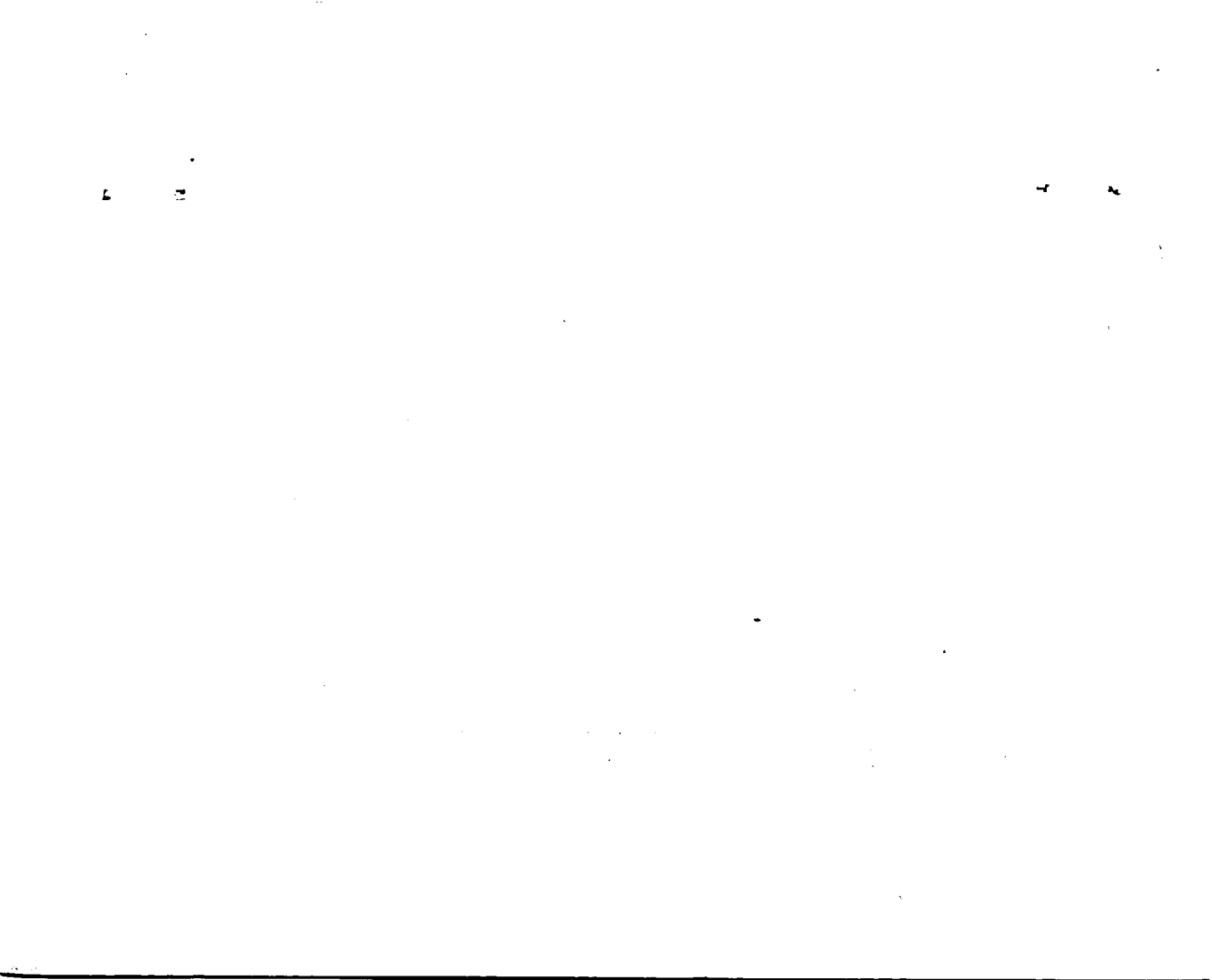
Address

Am. Falls, Ida

Filed

4-6 1925 James H. Hott
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

APR 8 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *Power*
City of *Ann. Falls*Registration District No. *25*
Vital Statistics District No. *2172*
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Compton*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *49336*
Registered No. *237*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR-DIVORCED.

Female *White* *single*
(Write the word.)

6. DATE OF BIRTH.

3 *10* *1925*
(Month) (Day) (Year)

7. AGE

*Premature birth*IF LESS than 1 day
how many *hrs.* or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Rella Compton

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Myrtle Alberts

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed *4 - 6* *1925* *Ymerius Not*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 *10* *1925*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to *191*
that I last saw h. *alive* on *191*
and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Premature
Stillborn(Duration) *Yrs.* *mos.* *ds.*Contributory
(Secondary)(Duration) *Yrs.* *mos.* *ds.*(Signed) *V. B. Logan* M. D.*19* (Address) *Ann. Falls Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *Yrs.* *mos.* *days* In the State *Yrs.* *mos.* *days*Where was disease contracted if not at place of death? *.....*Former or usual residence *.....*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Ann. Falls Ida**3 - 11* *1925*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

285-222-042-719
PLACE OF BIRTH

RECEIVED

MAY 4 1925

BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

City of Twin Falls

CERTIFICATE OF BIRTH

130878

No. _____ St. Registration District No. 37 State File No. _____

Hospital T. F. County Primary Registration ☒ District No. 1085 Local Registrar's No. ✓

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Mar. 22</u> 192 <u>5</u> (Month) (Day) (Year)
-------------------------------	---	--------------------------------------	--------------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Ray L. Steaver
RESIDENCE Tiber Idaho
COLOR white AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Cullom Ill
OCCUPATION Farmer

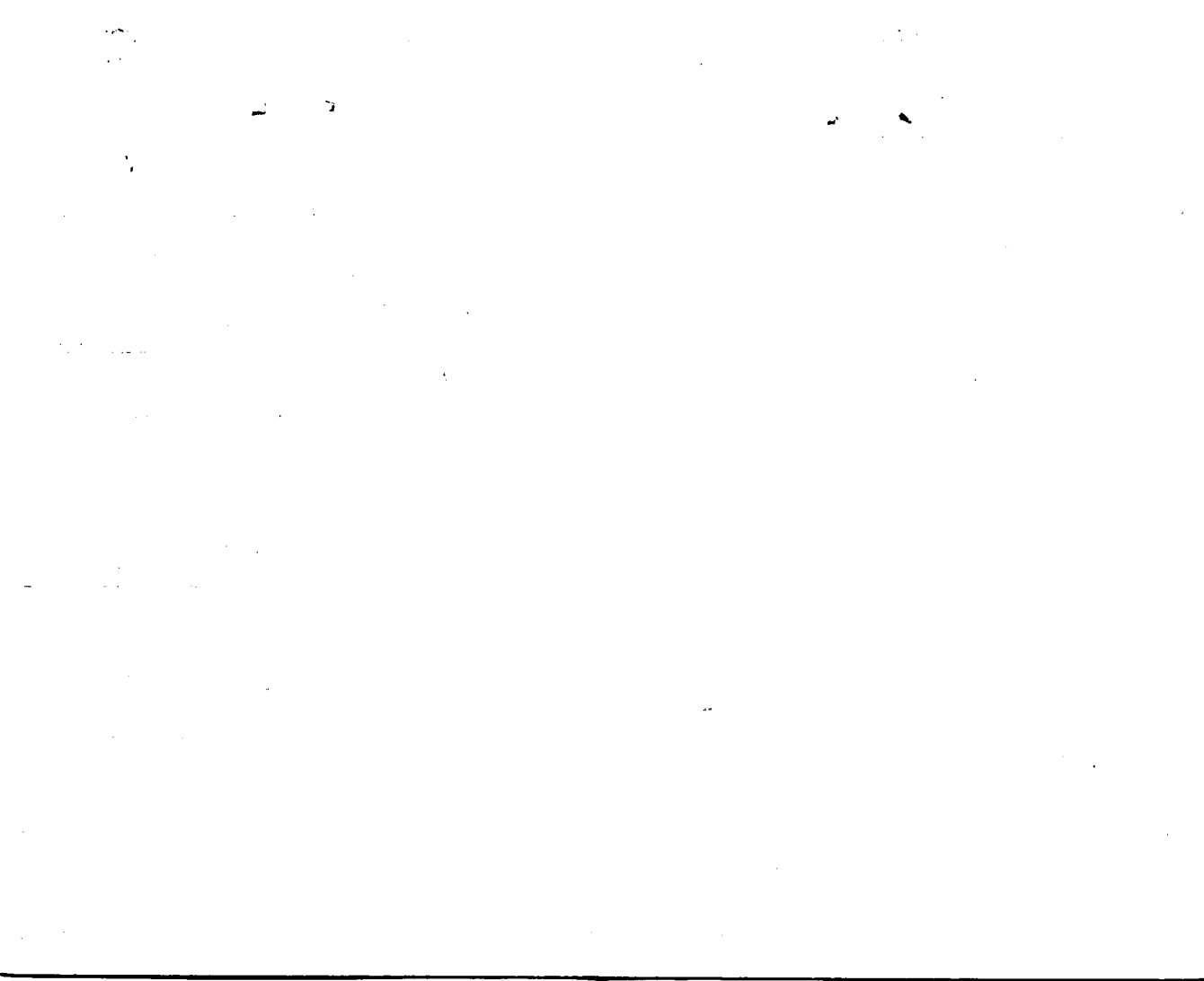
MOTHER
FULL MAIDEN NAME Ira Park
RESIDENCE Tiber Idaho
COLOR white AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Cullom Ill
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:57 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) A. A. Newberry
(Physician or midwife)
Address Idaho
Filed May 1 1925 John H. Hagglin
Registrar.



FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of Illinois District No. 37
 City of Chicago Registration District No. 1085
Not named County General Hospital St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Sheeran

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 19052Registered No. 1333

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white Single (Write the word.)

6. DATE OF BIRTH.

March 22 1915
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many hrs. or
 min.)
 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Iacks

10. NAME OF FATHER

Ray L. Sheeran

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Lou M. Park

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ray L. Sheeran

(Address)

Chicago

15.

Filed April 1-25 191

John F. Hough
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 22 1915
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at 16 M.

The CAUSE OF DEATH* was as follows

Still Born (Soleamia)
mother was toxic

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

19..... (Address) 99 Newberry M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

2001 Cemetery March 23 1915

20. UNDERTAKER

ADDRESS

St. Proke Chicago

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

219-212-042-299
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls, **RECEIVED**

City of Murtaugh, APR 13 1925

CERTIFICATE OF BIRTH

130906

No. 36 Registration District No. 36 State File No. 130906

Hospital home Primary Registration District No. 17 Local Registrar's No. 17

FULL NAME OF CHILD Clara Bailey

(Certificate of no value without full name of child)

Sex of Child <u>female</u>	<u>Twin</u> Triplet or other?	} and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Mar. 12</u> <u>1925</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? Neo S.

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME

George Leon Bailey

RESIDENCE

Murtaugh, Idaho.

COLOR

White

AGE AT LAST
BIRTHDAY

34
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

MOTHER
FULL MAIDEN
NAME

Myrtle Edith Sizemore

RESIDENCE

Murtaugh, Idaho.

COLOR

white

AGE AT LAST
BIRTHDAY

29
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Hw.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2:30 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) C. S. Sizemore

Physician

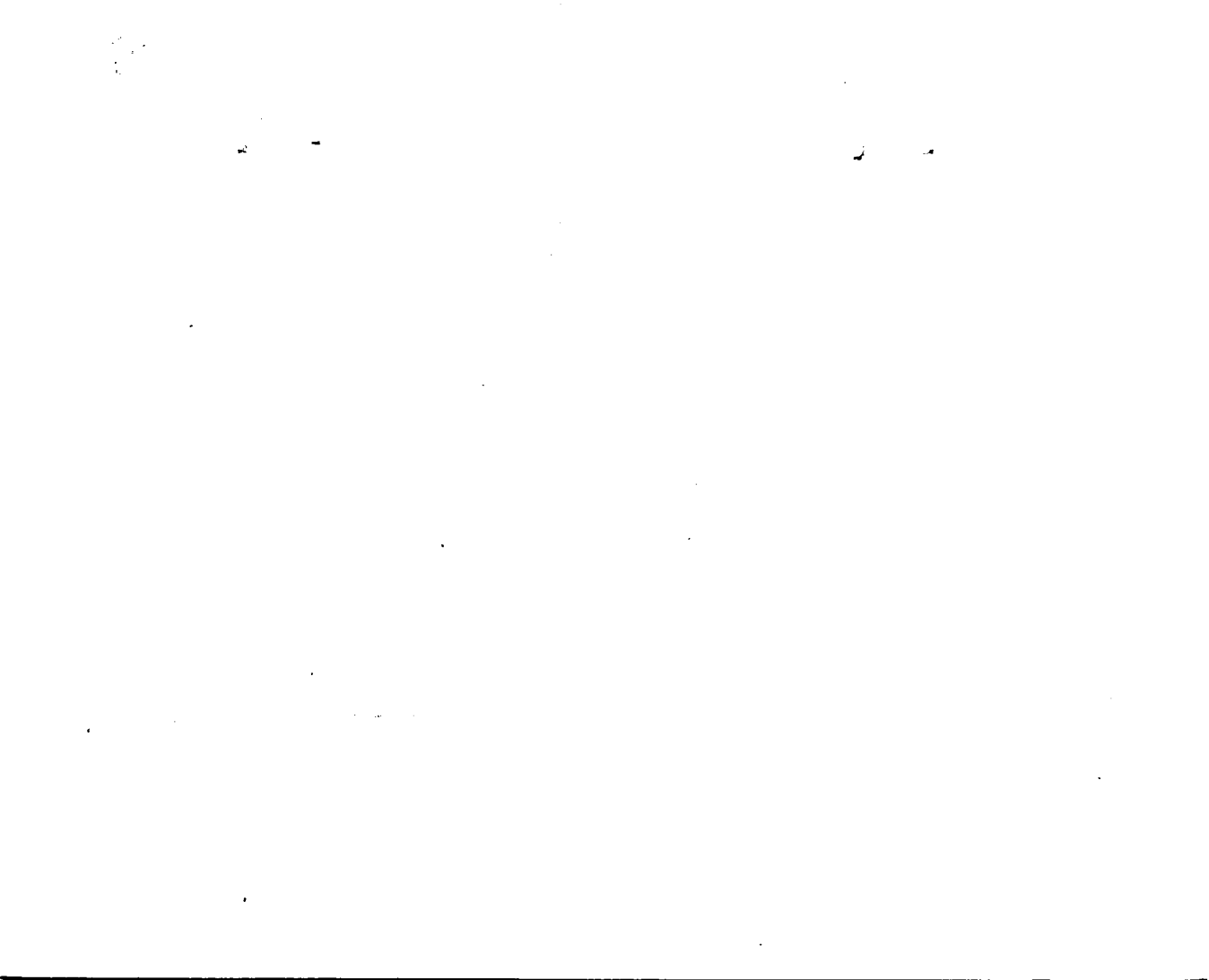
(Physician or midwife)

Address Kimberly, Idaho.

Filed March 22 1925

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Twin Falls

City of Murtaugh

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Bailey

RECEIVED
CERTIFICATE OF DEATH

Registration District No. 36

Registration District No. 36

(No.)

(St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49340

Local Registrar's No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

single

(Write the word)

6. DATE OF BIRTH

March

(Month)

12

(Day)

1925

(Year)

7. AGE

IF LESS than 1
day how many

hrs. or

min.?

0 Yrs.

0 Mos.

0 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Murtaugh, Idaho

10. NAME OF

Father

George Leon Bailey

11. BIRTHPLACE

OF FATHER

(State or Country) Idaho.

12. MAIDEN NAME

OF MOTHER

Myrtle Edith Sizemore

13. BIRTHPLACE

OF MOTHER

(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Bailey

(Address) Murtaugh

15.

Filed Mar 12 1925 J. N. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

(Month)

12

(Day)

1925

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn-asphyxia livida

breech presentation

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. N. Davis M. D.

3/12 1925 (Address) Kimberly

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Oakley, Idaho.

DATE OF BURIAL

Mar. 13 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

165-113-042-692
PLACE OF BIRTH

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls, **RECEIVED** DEPARTMENT OF PUBLIC WELFARE
City of Hansen **APR 13 1925** BUREAU OF VITAL STATISTICS **S**
BUREAU OF VITAL CERTIFICATE OF BIRTH
No. _____ St. **STATISTICS** District No. 36 State File No. 130907
Hospital Home Primary Registration District No. _____ Local Registrar's No. 18

FULL NAME OF CHILD Clifford Lloyd Jones
(Certificate of no value without full name of child)

Sex of Child	male	Twin Triplet or other?	} and {	Number in order of birth	Legiti- mate?	yes	Date of birth	Mar 13	1925
		(To be answered only in event of plural births)					(Month)	(Day)	(Year)

What bactericidal solution was used in eyes?.....Neo-S.....

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME	FATHER
----------------------	---------------

Loyd V. Jones

RESIDENCE

Hansen,

COLOR

white

AGE AT LAST BIRTHDAY 27
(Years)

BIRTHPLACE

Minn

OCCUPATION

Farmer

**FULL
MAIDEN
NAME**

Mannie Pearl Wiseman

RESIDENCE

~~Hansen,~~

COLOR

white

BIRTHPLACE

N.C.

OCCUPATION

HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Physician

(Physician or midwife)

Address Kimberly, Idaho.

Filed May 23 1925

Registrar.

Registrar.

JAN 09 1989

JAN 26 1944

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

992-123044-553
PLACE OF BIRTH

RECEIVED

APR 27 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

130935

County of Washington

City of Midvale

No. _____ St. _____

Registration District No. 57

File No.

Hospital _____

Primary Registration District No. 2154

Registered No. 20

FULL NAME OF CHILD

Still Born ✓

(Certificate of no value without full name of child.)

Sex of
Child

male

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

3/23 —

1925

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth... 6

Number of child of this mother now living, including present birth... 3

FULL
NAME

FATHER

John O. Ristrick

RESIDENCE

Midvale

COLOR

white

AGE AT LAST
BIRTHDAY

40
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Ethel M. Nelson

RESIDENCE

Midvale

COLOR

White

AGE AT LAST
BIRTHDAY

37
(Years)

BIRTHPLACE

Idaho

OCCUPATION

house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... still born...
on the date above stated.

still born

(Born alive or stillborn)

3 P. M.

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

F. Schmitt, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Winn I. Dahl

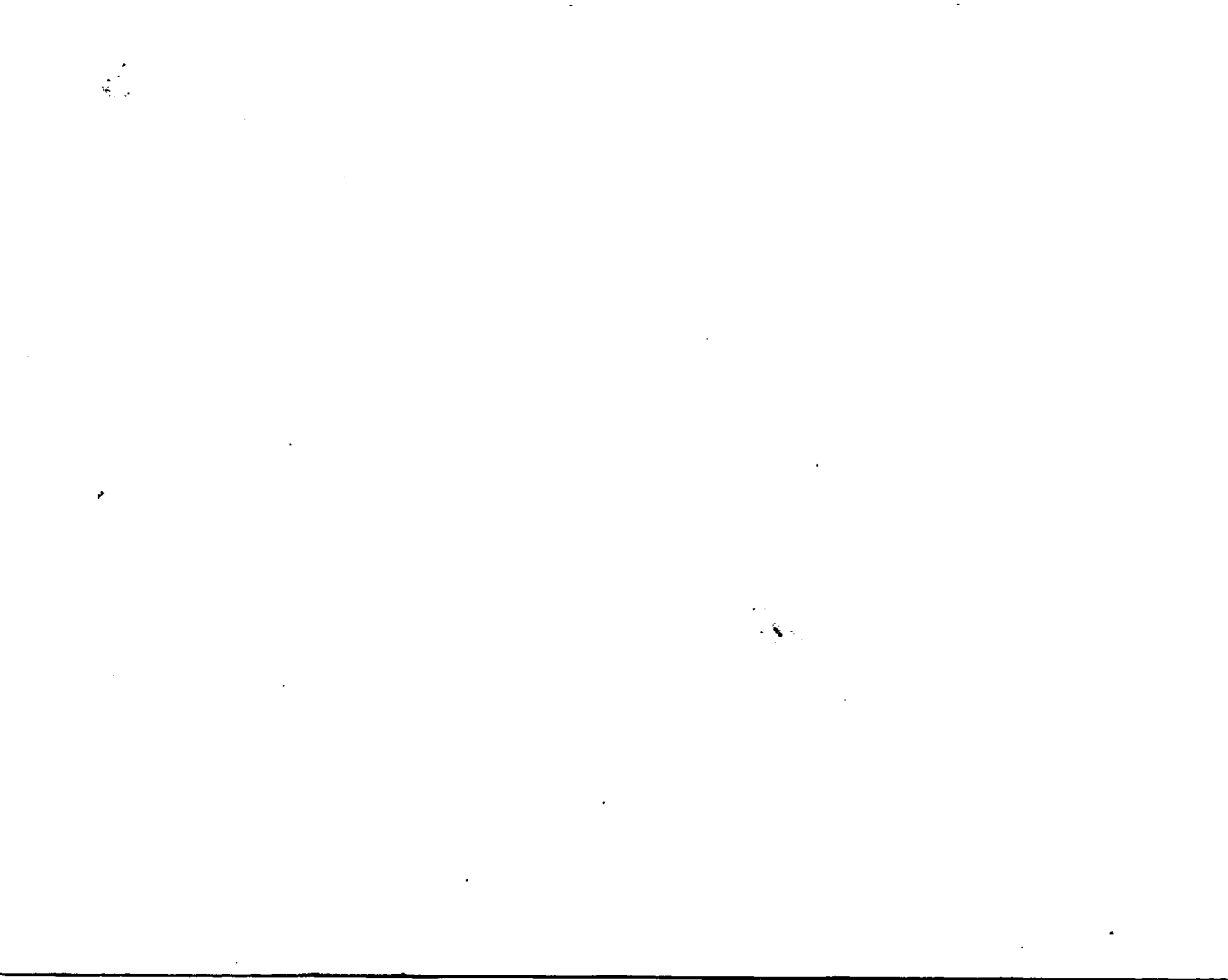
Filed

April 25 1925

Mrs. W. E. Keithley

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

918-110-644-315
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
APR 16 1925
BUREAU OF VITAL
STATISTICS

S

130937

County of Washington
City of Trainer
No. _____ St. _____ Reg. 86 File No. _____
Hospital _____ Primary Registration District No. 2112 Registered No. 130937
FULL NAME OF CHILD Baby Raymond
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Mar 14</u> 1925 <u>34 am</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? Silver Nitrate

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Fred Lee Raymond</u>	<u>Trainer</u>	<u>Delia Marie Lane</u>	<u>Weiser</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Okla</u>		BIRTHPLACE <u>Oregon</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>house wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 11 8 M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. S. Schmidt M.D.
(Physician or midwife)

Give names added from a supplemental report.

Address Waver Idaho
Filed April 10 1925 W. R. Hamilton
M. E. H. Registrar

Registrar.



State Of Idaho

DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, MAY 8 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

Place of Birth	CITY	W. W. W.	FILE NO.	130937
	ST.		DATE OF BIRTH	March 10, 1925
	COUNTY	W. W. W.	SEX OF CHILD	Male
	FATHER	Frank Raymond	MOTHER	Della Lane (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Junior Lee Raymond

RECEIVED MAY 14 1925

Mrs. F. L. Raymond
Signature of Father or Mother.

000000 00 000000

007886Z JUL 90 0000Z FM JCRC TO DIA

[illegible]

(continued)

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Lichtenthaler and Whistler (1973).

1230 *Estuaries*

... ..

and the β values are

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

413-111801-622
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

JUN 4 1925

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Ada

City of Boise

BUREAU OF VITAL

STATISTICS CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 2 State File No. 130980

Hospital St. Lukes Primary Registration District No. 1002 Local Registrar's No. 175

FULL NAME OF CHILD no name

(Certificate of no value without full name of child)

Sex of Child M Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth April 11 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 8

FATHER
FULL NAME Jay Mathews

RESIDENCE Rt Rose St Boise Ida

COLOR White AGE AT LAST BIRTHDAY 50 (Years)

BIRTHPLACE Ill.

OCCUPATION Contractor

MOTHER
FULL MAIDEN NAME Bessie Osborne

RESIDENCE Rt Boise Idaho

COLOR White AGE AT LAST BIRTHDAY 42 (Years)

BIRTHPLACE Guthrie Center Iowa

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 12 10 P M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) A. B. Borch

(Physician or midwife)

Address Boise Ida

Filed 5-31-25 1925 R. H. Pratt

Registrar.

Registrar.

THIS IS A LEGAL DOCUMENT AND IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE BUREAU OF VITAL STATISTICS, STATE OF NEW YORK.

PLACE OF BIRTH

RECEIVED

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

189980

NAME OF CHILD **WILLIAM**
 SEX **M**
 DATE OF BIRTH **1900**
 PLACE OF BIRTH **NEW YORK**
 HOSPITAL **NEW YORK**
 PRIMARY PHYSICIAN **NEW YORK**
 SECONDARY PHYSICIAN **NEW YORK**
 REGISTERED **NEW YORK**
 AGE AT LAST BIRTHDAY **NEW YORK**
 COLOR **NEW YORK**
 BIRTHPLACE **NEW YORK**
 OCCUPATION **NEW YORK**

What method of birth control was used in event of a child of this mother, including present and future?
 NAME **NEW YORK**
 FULL NAME **NEW YORK**
 RESIDENCE **NEW YORK**
 AGE AT LAST BIRTHDAY **NEW YORK**
 COLOR **NEW YORK**
 BIRTHPLACE **NEW YORK**
 OCCUPATION **NEW YORK**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of **WILLIAM**, who was born on the date above stated.
 When there was no attending physician, I witnessed the birth and the mother was **NEW YORK**.
 I have signed this certificate and the mother's name is one that either practiced or allowed other evidence of life after birth.
 Give names added from a supplemental report.
 (Physician or midwife)
 Signature **NEW YORK**
 Date **NEW YORK**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-26 M. 1-19.

1. PLACE OF DEATH

County of *Ada*

City of *Boise*

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

RECEIVED
MAY 6 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *2*

Registration District No. *100.2*

(No. *St. Lukes Hospital*)

Baby Mathews

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *49091*

Local Registrar's No. *94*

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

6. DATE OF BIRTH

Apr. 11 - 1925

(Month)

(Day)

(Year)

7. AGE

Still Born

Yrs.

Mos.

ds.

IF LESS than 1
day how many
hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

None.

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF
Father

Jay Mathews

11. BIRTHPLACE
OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME
OF MOTHER

Bessie Osborn

13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Idaho

15.

Filed *4-30-25* 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 11, 1925.

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 11, 1925. to *April 11, 1925.*

that I last saw him *live* on *19*,

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Still born (Prolapsed cord)

(Duration) *0* yrs. *0* mos. *0* ds.

Contributory

(Secondary)

(Duration) *0* yrs. *0* mos. *0* ds.

(Signed)

W. McBratney M. D.

4/11 1925 (Address) *Boise, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *0* yrs. *0* mos. *0* days, State *0* yrs. *0* mos. *0* ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

4/11/25

20. UNDERTAKER

W. McBratney

ADDRESS

Boise, Idaho

*Albert,
Dr. Back.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

239,124,003-891
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock.

City of Pocatello.

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 28 State File No. 131056

Hospital Pocatello, General Primary Registration District No. 2161 Local Registrar's No. 6974

FULL NAME OF CHILD Stillborn.

(Certificate of no value without full name of child)

Sex of Child Male. Twin Triplet or other? } and { Number in order of birth 1 Legitimate? yes. Date of birth April 4, 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth I Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Amasa Arthur Bliss.
RESIDENCE Fargo Apts.
COLOR White. AGE AT LAST BIRTHDAY 26
(Years)
BIRTHPLACE Tucker, Utah.
OCCUPATION Mgr. B. R. Owen Co.,

MOTHER
FULL MAIDEN NAME Pearl LaRue Hiatt.
RESIDENCE Fargo Apts.
COLOR White. AGE AT LAST BIRTHDAY 24
(Years)
BIRTHPLACE Payson, Utah.
OCCUPATION Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 5:50 A. M.
on the date above stated. { Stillborn }

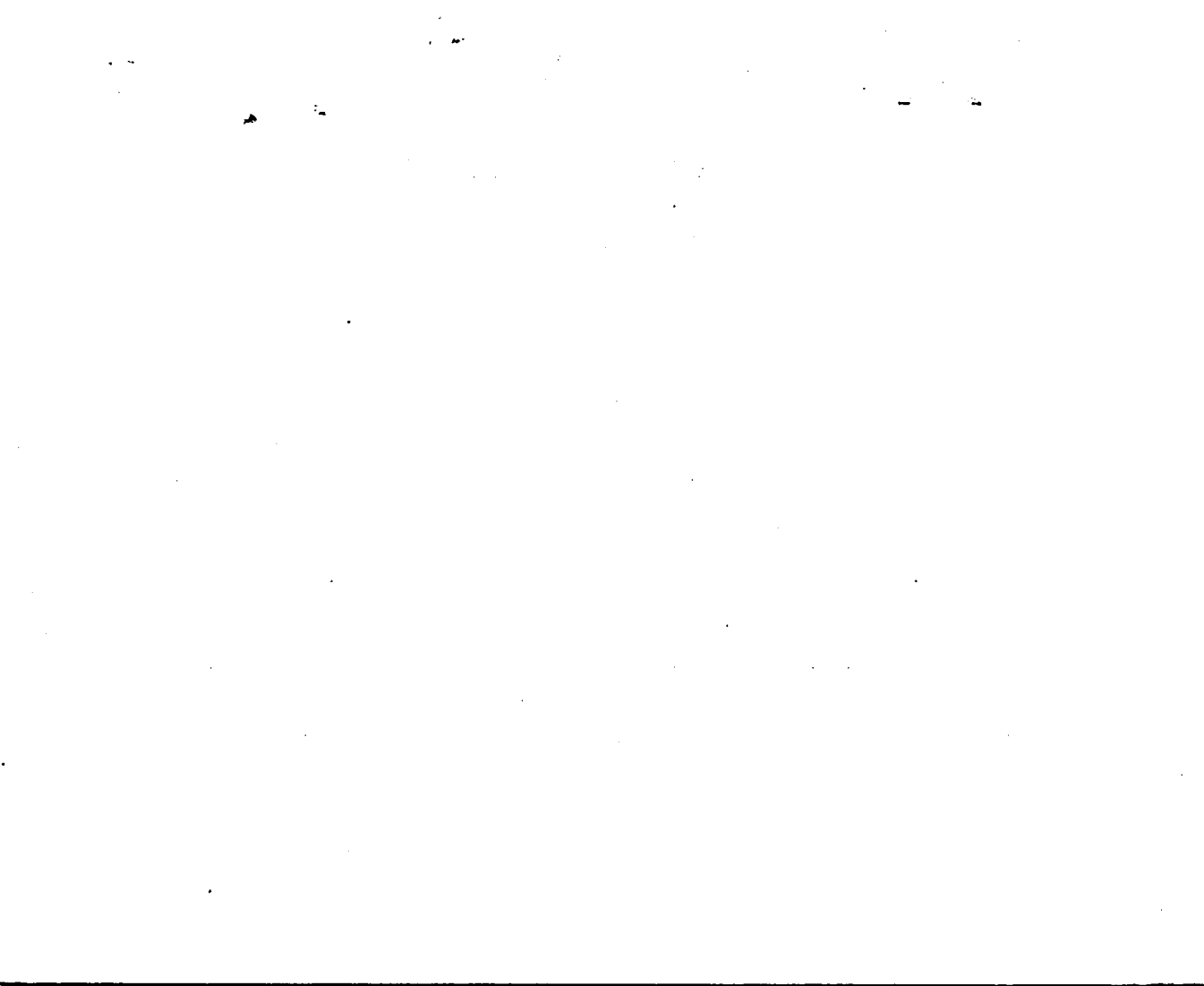
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1925

(Signature) W. T. Howard MD
(Physician or midwife)

Address Pocatello, Idaho.

Filed 5/1 1925 W. T. Howard
Registrar. Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Bliss

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49400

Local Registrar's No. 4597

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Infant
(Write the word)

6. DATE OF BIRTH

April 24 1925
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF
Father

A. A. Bliss

11. BIRTHPLACE
OF FATHER

(State or Country)

Utah

12. MAIDEN NAME
OF MOTHER

Pearl Hiatt

13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. A. Bliss

(Address) Pocatello Ida.

15.

Filed 4/24 1925

J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 24 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1925 to Apr 24, 1925, that I last saw him alive on Stillborn 1925, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Stillborn
Forceps delivery
(Duration) yrs. mos. no ds.

Contributory
(Secondary)

(Signed) J. F. Howard, M.D.
4/24/1925 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days State yrs. mos. ds.
Where was disease contracted Pocatello General Hospital
if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Salt Lake City Utah

DATE OF BURIAL

Apr 25 1925

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

719-108-008-389

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

MAY 13 1925

BUREAU OF VITAL STATISTICS

131093

County of *Bear Lake*

City of *Bloomington*

BUREAU OF VITAL

CERTIFICATE OF BIRTH

No. St. Reg. No.

STATISTICS

No. *6-3*

State File No. *280*

S

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

Newell Elmer Parker

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of birth

Apr 8

1925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

3

Number of child of this mother now living, including present birth

2

FULL
NAME

FATHER

Elmer Parker

FULL
MAIDEN
NAME

MOTHER

Lulu Christiansen

RESIDENCE

Bloomington Ida

RESIDENCE

Bloomington Ida.

COLOR

White

AGE AT LAST
BIRTHDAY

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { *Stillborn* } at *5.55 P.M.* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

O O Moore M.D.
Child about 6 mo. Cause
death unknown.

(Physician or midwife)

Address

Filed

6-3

1925

Mrs. J. Skinner

Registrar.

Registrar.

2



F. J.

State Of Idaho
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, JUN 16 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

Place of Birth	CITY	<i>Bloomington</i>	FILE NO.	131093
	ST.		DATE OF BIRTH	<i>Nov 22 1923</i>
	COUNTY	<i>Bear Lake</i>	SEX OF CHILD	<i>Male</i>
	FATHER	<i>Elmer Parker</i>	MOTHER	<i>Lula Christiansen</i> (Maiden Name)

RECEIVED
JUN 29 1925
BUREAU OF VITAL
STATISTICS

I HEREBY CERTIFY that the child herein described has been named:
Newell Elmer Parker

X Lula Parker
Signature of Father or Mother.

IDAHO

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. R.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

\$94-130-006-559
PLACE OF BIRTH

RECEIVED
JUN 11 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Laurel

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. St.

Registration District No. 121

State File No. 131222

Hospital.....

Primary Registration District No. 2194

Local Registrar's No. 165

FULL NAME OF CHILD.....

(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>4-30-1925</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth.....		Number of child of this mother now living, including present birth.....	
FULL NAME <u>Arthur Messersmith</u>	FATHER	FULL MAIDEN NAME <u>Ada Neubauer</u>	MOTHER
RESIDENCE <u>Laurel</u>		RESIDENCE <u>Laurel</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>42</u> (years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>42</u> (years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Born alive at 2 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Edwin Ciller M.D.

Give names added from a supplemental report.

(Physician or midwife) Shelley, Ida

Address June 8 1925

Filed June 8 1925

Registrar.

Registrar.

CERTIFICATE OF BIRTH

131553

No. of Birth Record

No. of Hospital Record

Full Name of Child (Print Name of Child)

Sex of Child (Male or Female)

Date of Birth (Month, Day, Year)

Place of Birth (City, State, Country)

Weight at Birth (Pounds, Ounces)

Length at Birth (Inches)

Head Circumference at Birth (Inches)

Birth Record No. (Print Name of Child)

Number of Child of this Mother (Including present birth)

Number of Child of this Mother (Including present birth)

Full Name of Father (Print Name of Father)

Full Name of Mother (Print Name of Mother)

Residence of Father (City, State, Country)

Residence of Mother (City, State, Country)

Color of Child (Print Name of Child)

Color of Child (Print Name of Child)

Birthplace of Child (City, State, Country)

Birthplace of Child (City, State, Country)

Occupation of Child (City, State, Country)

Occupation of Child (City, State, Country)

Age at Last Birthday (Years)

Age at Last Birthday (Years)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date above stated.

When there was no attending physician or midwife, then the father, mother or other person should make this report. A stillborn child is one that neither lives nor shows other evidence of life after birth.

Give names added from a supplemental report.

Signature of Attending Physician or Midwife

Signature of Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

750-7116-013
PLACE OF BIRTH 768

STATE OF IDAHO

S

County of Bute

City of Arco

No. _____ St. _____

Hospital _____

JUN 10 1925

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

131245

Registration District No. 59 State File No. 18

Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Male Twin One and { Number in order of birth — } Legitimate yes Date of birth 5 16 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyol 10%

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Emist George
RESIDENCE Arco Ida.
COLOR White AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Arco Ida.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Jasie Johnson
RESIDENCE Arco Ida.
COLOR White AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Blackfoot Ida.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at Arco Ida. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 192____

(Signature) E. T. Parkinson
Physician
(Physician or midwife)

Address Arco, Ida.

Filed June 17 1925 D. E. Deegan
Registrar. Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

662-108,010-491
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville
City of Idaho Falls

MAY 18 1925

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

131263

No. _____ St. _____ Registered District No. 73 State File No. _____
Hospital Spencer Primary Registration District No. 2100 Local Registrar's No. 134

FULL NAME OF CHILD Richard Garth Foster
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? 1 and { Number in order of birth 3 Legitimate? yes Date of birth April 4 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Jesse Drake Foster</u>	<u>Driggs Idaho.</u>	<u>Vera Drake</u>	<u>Driggs Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Bates Idaho.</u>		BIRTHPLACE <u>Bates Idaho.</u>	
OCCUPATION <u>Rancher</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:05 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

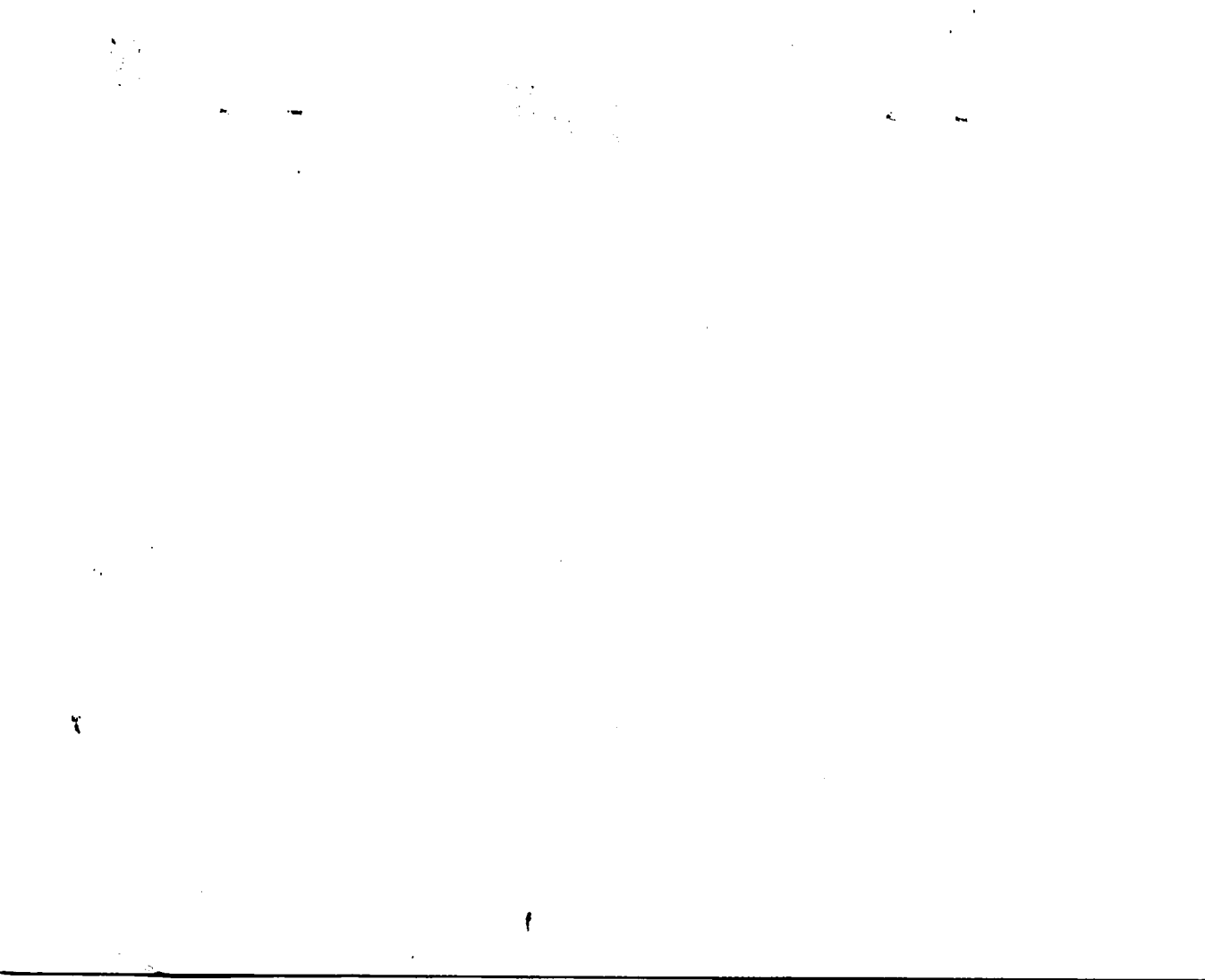
(Signature) Harry A. Hillman
(Physician or midwife)

Address Idaho Falls

Filed Apr 17 1925 - Certified

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 18 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
 City of Idaho Falls Registration District No. 214-0
 (No. Spencer Hope St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Foster

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 49481
 Registered No. 86

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH April March 4 1925
 (Month) (Day) (Year)

7. AGE Born dead IF LESS than 1 day
 Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work 2 co.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho Falls Ida.
 (State or Country)

10. NAME OF FATHER Jess Foster

11. BIRTHPLACE OF FATHER Idaho
 (State or Country)

12. MAIDEN NAME OF MOTHER Berna Drake

13. BIRTHPLACE OF MOTHER Idaho
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jess Foster
 (Address) Driggs Ida.

15. Filed Apr 2 19 25 Wm W Wilson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 4 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 19... to 19...
 that I last saw h... alive on 19...
 and that death occurred on the date stated above, at... M.
 The CAUSE OF DEATH* was as follows:

Still born - lungs filled w
amniotic fluid. very very
indistinct heart beat.
 (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry L. Wilkerson M. D.

4-6 19 25 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls Ida DATE OF BURIAL Apr 6 19 25

20. UNDERTAKER Chas Hays ADDRESS Idaho Falls Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

692-218,016-364
PLACE OF BIRTH

RECEIVED
MAY 12 1925
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Burley

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 117 State File No. 131340

Hospital _____ Primary Registration District No. 2196 Local Registrar's No. 3105

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	<u>Twin</u> <u>Triplet</u> <u>or other?</u> (To be answered only in event of plural births)	} and { <u>Number</u> <u>in order</u> <u>of birth</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>4-18</u> (Month) (Day) (Year) <u>1925</u>
----------------------------	--	---	-----------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME A. D. Fisher
RESIDENCE Burley, Ida.
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Kansas
OCCUPATION Section-hand

MOTHER
FULL MAIDEN NAME Florence Tomlinson
RESIDENCE Burley, Ida.
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Mo.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Dr. J. C. Patterson
Physician

(Physician or midwife)

Address

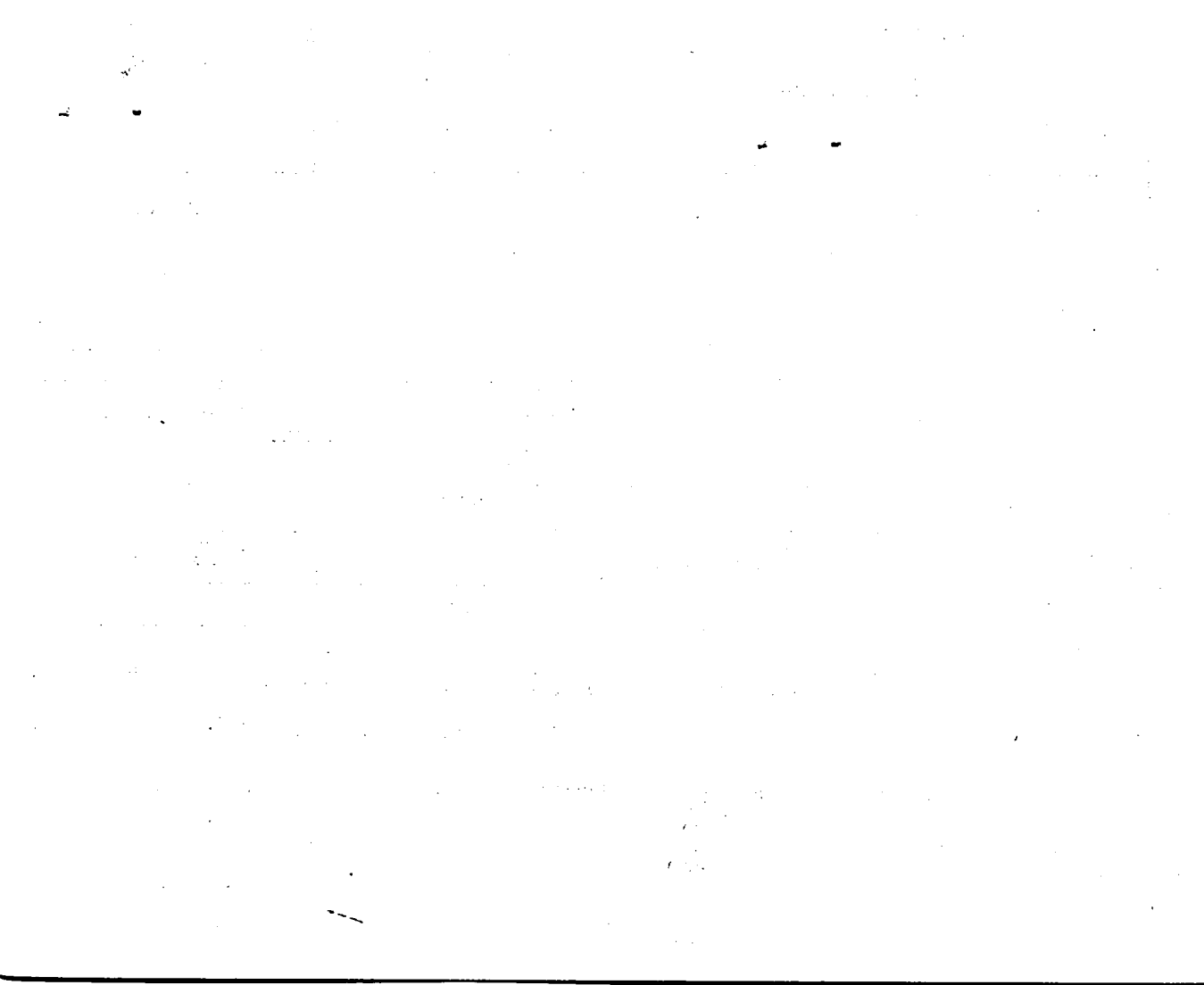
Burley, Ida.

Filed 5-5-

1925

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn---- Fisher

RECEIVED CERTIFICATE OF DEATH

MAY 12 1925 District No. 117

BUREAU OF VITAL STATISTICS Registration District No. 2196 (St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49520

Local Registrar's No. 781

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

April 18 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
..... hrs. or min.?

..... Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burley, Idaho.

10. NAME OF

Father A. D. Fisher

11. BIRTHPLACE

OF FATHER
(State or Country) Kansas

12. MAIDEN NAME

OF MOTHER Florence Tomlinson

13. BIRTHPLACE

OF MOTHER
(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. D. Fisher

(Address) Burley, Ida.

15.

Filed Apr. 19 1925 L. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 18 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19,

that I last saw him alive on 19,

and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Stillborn,
Cause unknown.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.

419 1925 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.

DATE OF BURIAL

Apr. 18 1925

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia;** **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles;** **Whooping cough;** **Chronic valvular heart disease;** **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.;** **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident;** **Revolver wound of head—homicide;** **Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

315-1270-016-249
PLACE OF BIRTH

MAY 12 1925

STATE OF IDAHO

BUREAU OF VITAL STATISTICS
BUREAU OF PUBLIC WELFARE
STATISTICS

S

CERTIFICATE OF BIRTH

County of *Cassia*

City of *Kenyon - near Burley*

No. *17 mile SW* St.

Registration District No. *117*

File No. *131346*

Hospital

Primary Registration District No. *2196*

Registered No. *3120*

FULL NAME OF CHILD

Turner

(Certificate of no value without full name of child.)

Sex of

Child *male*

Twin
Triplet
or other?

1 and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

4 27 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *1*

Number of child of this mother now living, including present birth *0*

FULL
NAME

FATHER

Raymond Ambrose Turner

FULL
MAIDEN
NAME

MOTHER

Fanny Smith

RESIDENCE

Kenyon - 17 miles

RESIDENCE

SW of Burley

COLOR

white

AGE AT LAST
BIRTHDAY

27
(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

24
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

born dead, at *12:10 A. M.*
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

O. P. Wham
md

(Physician or midwife)

Give names added from a supplemental report.

Address

Burley Idaho

Filed

5-5

1925

D. J. C. Patterson
Registrar.

Registrar.



State Of Idaho
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, JUN 16 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

Stillborn

Place of Birth	{	CITY <u>Kenyon</u>	FILE NO. <u>131346</u>
		ST. <u>Idaho</u>	DATE OF BIRTH <u>April 27</u>
		COUNTY <u>Cassia</u>	SEX OF CHILD <u>Male</u>
		FATHER <u>Raymond A. Tanner</u>	MOTHER <u>Lanny Smith</u> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

There was no name as the child was born dead.

Raymond A. Tanner
Signature of Father or Mother.

RECEIVED
JUN 23 1925
BUREAU OF VITAL
STATISTICS

DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

UNITED STATES OF AMERICA

Washington, D. C.

1914

THE BUREAU OF PLANT INDUSTRY, U. S. DEPARTMENT OF AGRICULTURE, has the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
J. H. HARRIS, Chief

Enclosed for you are two copies of a report of the Bureau of Plant Industry, U. S. Department of Agriculture, on the subject of the "Cultivation of the Rubber Tree in the United States". This report was prepared by Mr. J. H. Harris, Chief of the Bureau, and Mr. W. H. Henshaw, Assistant Chief, and is published in the "Bureau of Plant Industry Bulletin" No. 100, 1914.

Very truly yours,
J. H. HARRIS, Chief

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Cassia

City of Kenyon, Newbury

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

MAY 12 1925

BUREAU OF VITAL STATISTICS

(No. 117)

CERTIFICATE OF DEATH

Registration District No. 2196

(St.)

Tanner

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49519

Local Registrar's No. 782

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Infant

(Write the word)

6. DATE OF BIRTH

4/27 1925
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF Father

Raymond Ambrose Tanner

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Fanny Smith

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. H. Shum, Burley, Idaho

15.

Filed 4-28 1925 Dr. J. E. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 27 1925, to Apr 27 1925, that I last saw him alive on 19, and that death occurred on the date stated above, at 0 M.

The CAUSE OF DEATH* was as follows:

Premature detachment of Placenta about six weeks before term

Contributory 3 weeks ante term

(Duration) yrs. mos. ds.

(Signed) E. H. Shum M. D.
(Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Oakley

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia;** **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

434-224.016-363
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

131366

County of Cassia

City of Oakley

RECEIVED

JUN 10 1925

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No.

St.

Registration District No.

137

State File No.

131366
137
S

Hospital

Primary Registration District No. 299

Local Registrar's No. 46

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

female

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

5

34

1925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? Hydroz

Number of child of this mother, including present birth 31

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

Ernest M. Murray

RESIDENCE

Oakley Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

3

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Corba Collins

RESIDENCE

Oakley

COLOR

white

AGE AT LAST
BIRTHDAY

30

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 9:30 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. H. Theobald

(Physician or midwife)

Address

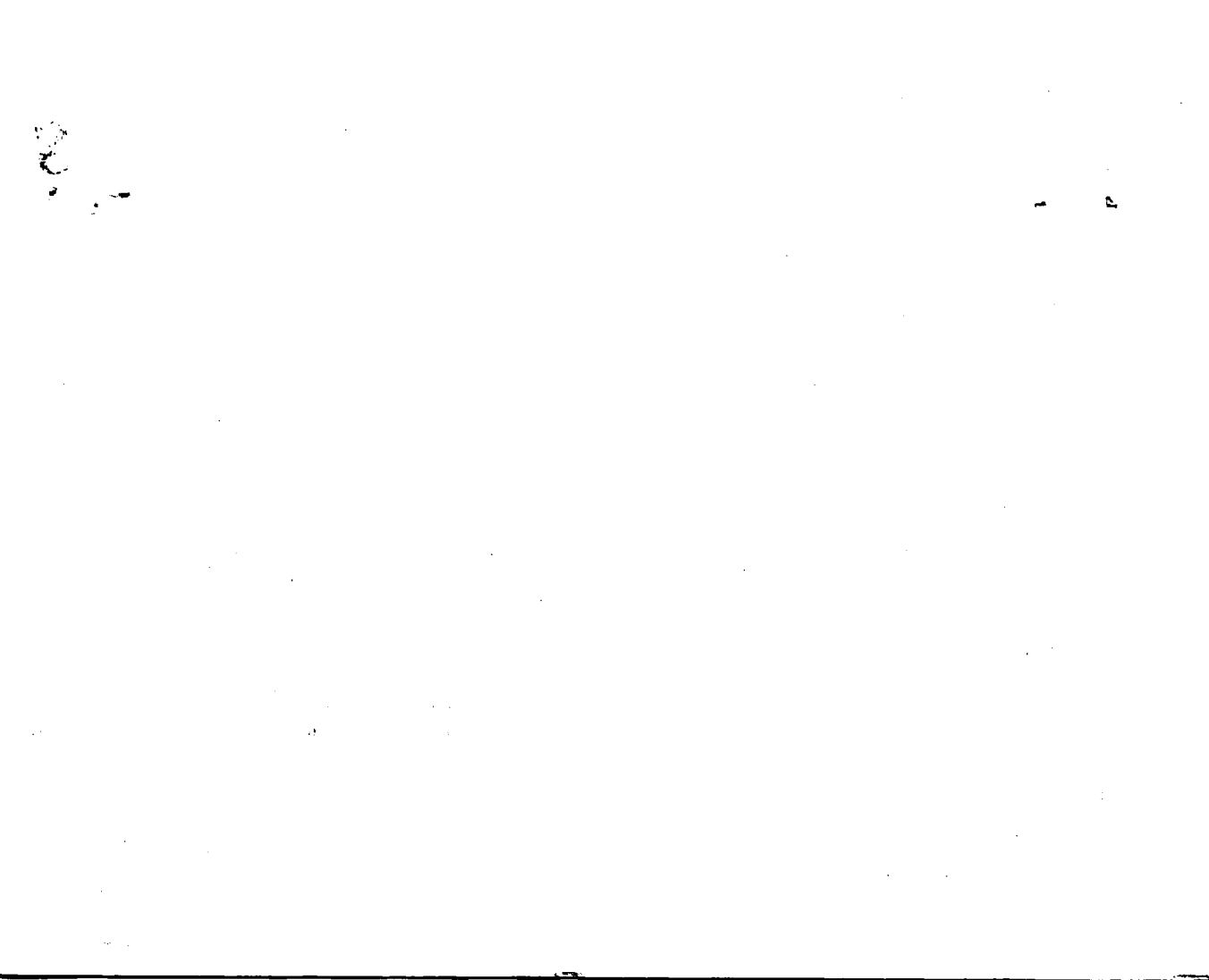
Oakley Idaho

Filed

June 10 1925

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Cassia*City of *Cashley*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUN 10 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *120*Registration District No. *2149*

49533

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *XIV*Registered No. *8*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

W. Name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

*May**5**1925*

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Cashley Idaho

10. NAME OF FATHER

Eugene Mc Murray

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Eva Collins

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Eugene Mc Murray

(Address)

Cashley Id.

15.

Filed

June 12 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

*May**5**1925*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Cause of Death Unknown

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

W. H. (Signature)

M. D.

6/1/1925

(Address)

Cashley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cashley Idaho**May 6 1925*

20. UNDERTAKER

ADDRESS

*Eugene Mc Murray**Cashley Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

551-210-016755
PLACE OF BIRTH

RECEIVED
MAY 16 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of _____
City of _____
No. _____ St. _____
Hospital _____
Registration District No. 3 File No. 131371
Primary Registration District No. 2007 Registered No. 22
FULL NAME OF CHILD David at birth
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Apr 10</u> 192 <u>5</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth... 2 Number of child of this mother now living, including present birth... 1

FATHER
FULL NAME Vernon F. Evans
RESIDENCE Pomeroy
COLOR W AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Kan
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Velma T. Jentery
RESIDENCE Pomeroy
COLOR W AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Kan
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born stillborn, at 6-30 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. Muldrew

(Physician or midwife)

Give names added from a supplemental report.

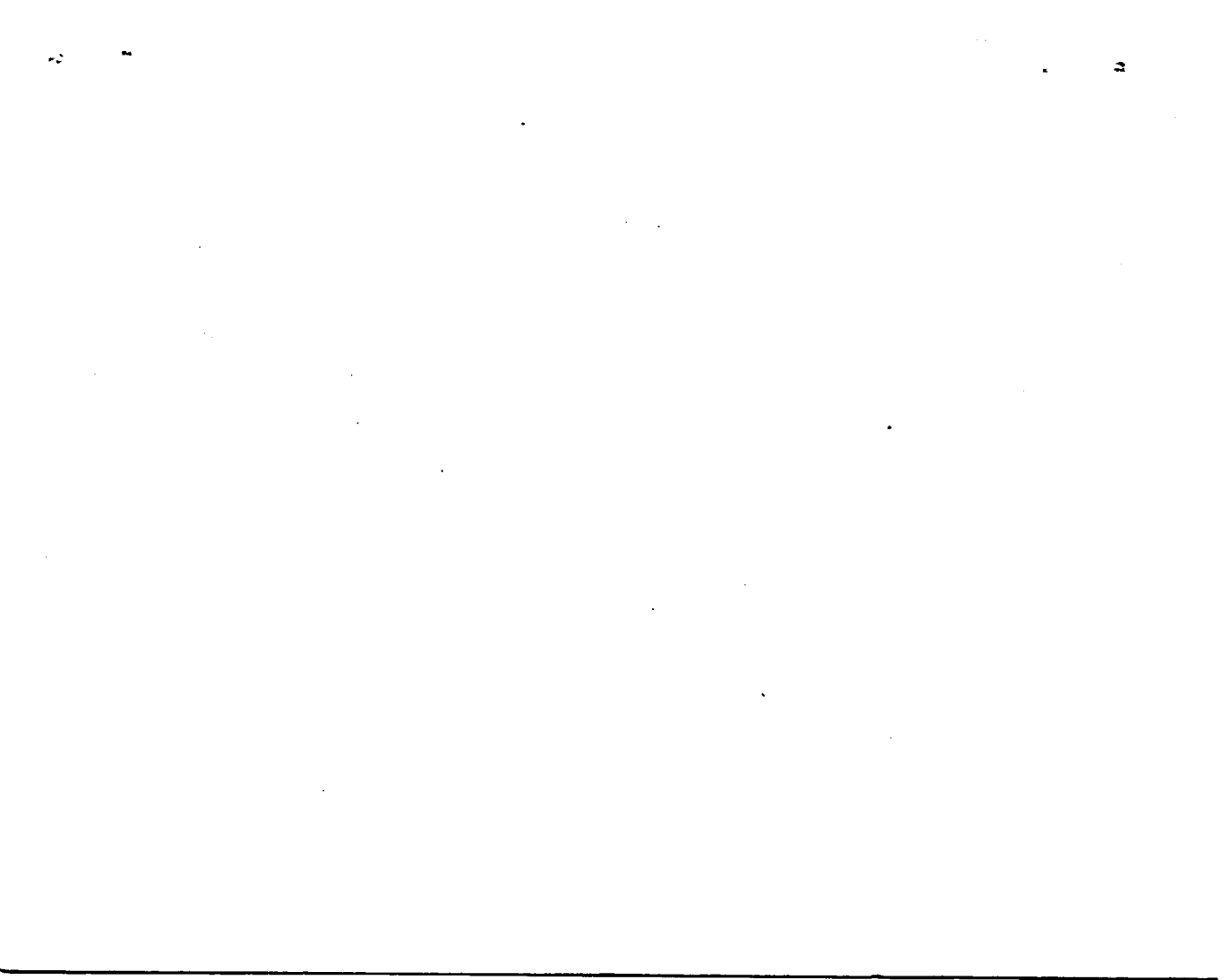
_____, 19____

Registrar.

Address _____

Filed 6-10 1925

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 18 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Registration District No. 200

(No. St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49504

Local Registrar's No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant - died at birth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

April 10 1925
(Month) (Day) (Year)

7. AGE

Still born IF LESS than 1 day how many hrs. or min.?
None

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Canyon Co., Idaho

10. NAME OF Father

Vernon F. Evans

11. BIRTHPLACE OF FATHER

(State or Country) Kans - Mitchell Co.

12. MAIDEN NAME OF MOTHER

Belma T. Jentry

13. BIRTHPLACE OF MOTHER

(State or Country) Kans. Mitchell Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vernon F. Evans

(Address) Pomeroy, Idaho

15.

Filed 5-1 1925 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 10 1925 to Apr. 10 1925

that I last saw him alive on Apr. 10 1925

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Strangulation

(Duration) yrs. mos. ds.

Contributory Cause of Death (Secondary) Bunch presentation

(Duration) yrs. mos. ds.

(Signed) W. B. Walcott M. D.

Apr. 19 1925 (Address) Pomeroy, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pomeroy, Idaho

DATE OF BURIAL

Apr. 10 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

449-128-

1-1-18

PLACE OF BIRTH

County of

Canyon

City of

Middleton

No.

St.

Hospital

RECEIVED
MAY 11 1925
BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

Registration District No.

3

File No.

121391

Primary Registration District No.

2005

Registered No.

73

FULL NAME OF CHILD

Sex of Child

male

Is it
Twin
or other?

and

Number
in order
of birth

7th

Legiti-
mate?

yes

Date of Birth

April 28

1925

FULL NAME

P. J. Murphy

FATHER

RESIDENCE

Middleton

COLOR

white

AGE AT LAST BIRTHDAY

40
(Years)

BIRTHPLACE

Kansas

OCCUPATION

Carpenter

FULL MAIDEN NAME

Stella Jarvis

MOTHER

RESIDENCE

Idaho, Middleton

COLOR

white

AGE AT LAST BIRTHDAY

43
(Years)

BIRTHPLACE

Idaho

OCCUPATION

House wife

Number of child of this mother, including present birth

7

Number of children of this mother now living, including present birth

6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Stillborn

at 10 P.M.

on the date above stated.

(Born alive or stillborn)

"When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth."

(Signature)

J. W. James MD

(Physician or midwife)

Given names added from a supplemental report.

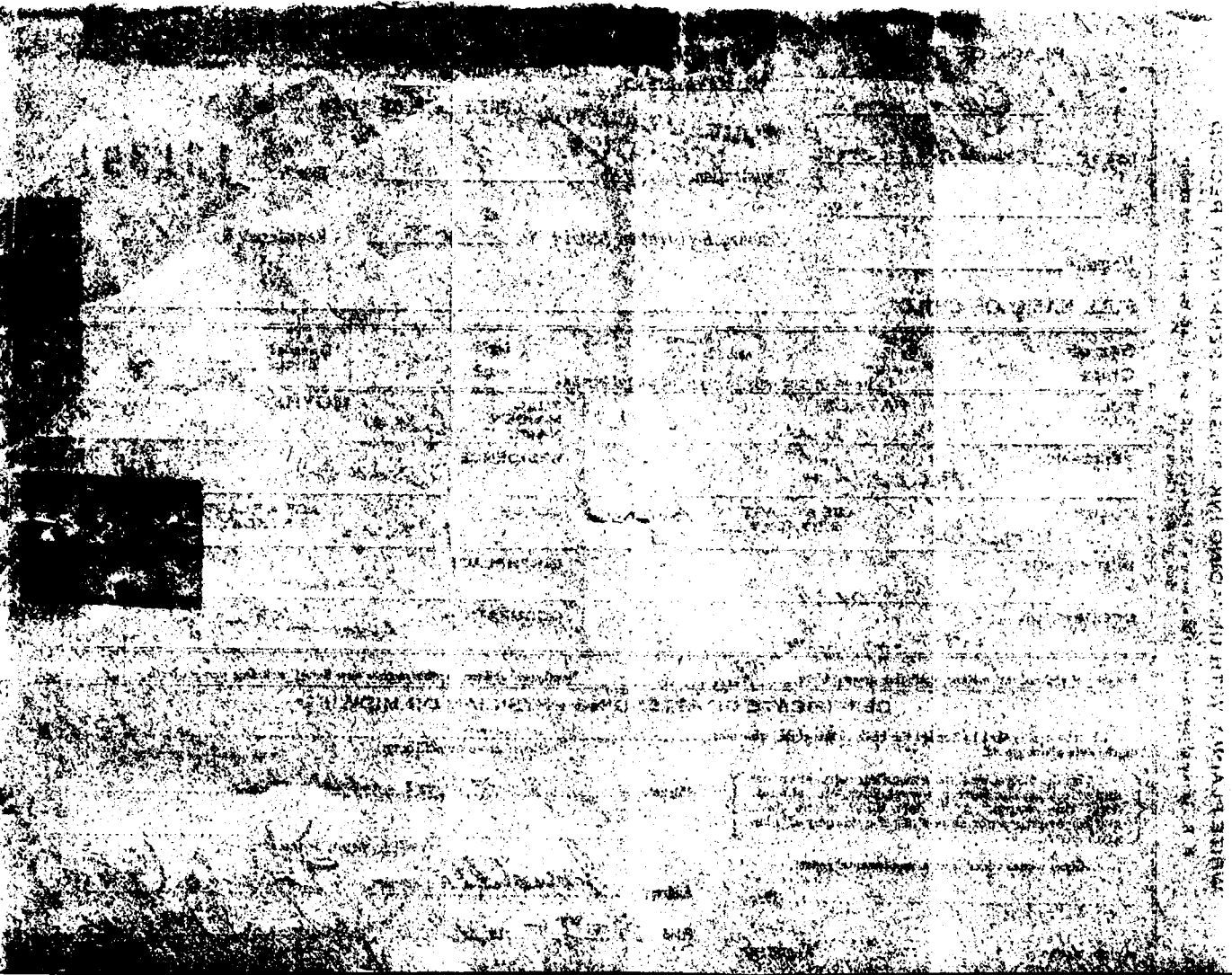
Address

Middleton, Idaho (J.B.M.)

Filed

5-2-25

John S. Meyer - Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

266-1221-396
PLACE OF BIRTH

RECEIVED
MAY 9 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

131437

County of Franklin

City of Preston

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 27 State File No. _____

Hospital _____ Primary Registration District No. 2119 Local Registrar's No. 10A

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	<u>Twin</u> Triplet or other?	and { <u>Number</u> in order of birth }	Legitimate? <u>Yes</u>	Date of birth <u>April 22, 1925</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Archie Kofoed
RESIDENCE Preston, Idaho
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Idaho
OCCUPATION School Teacher

MOTHER
FULL MAIDEN NAME Mable Crockett
RESIDENCE Preston, Idaho
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 1:15 a m. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 192____

(Signature)

R. R. Cutler
Physician

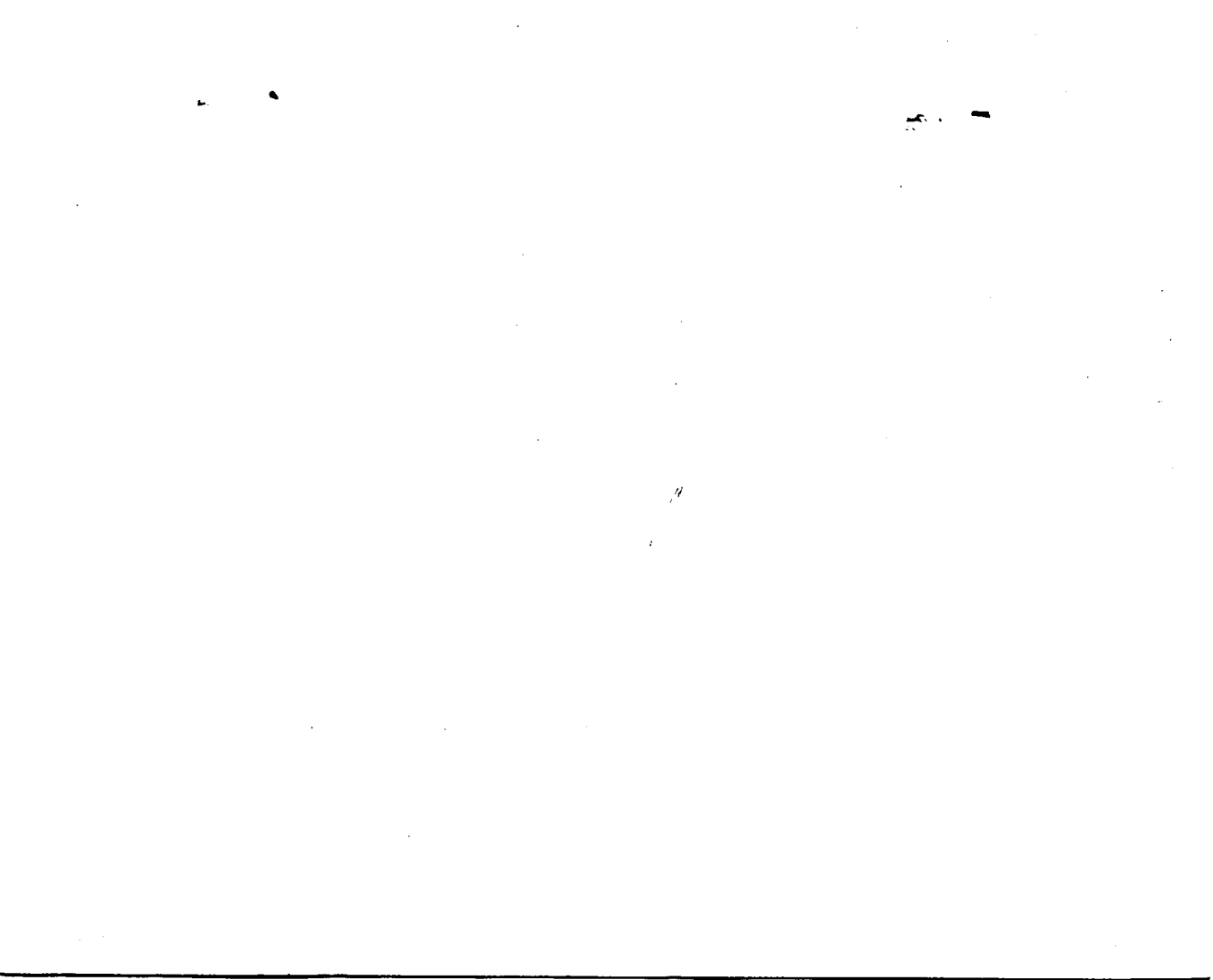
(Physician or midwife)

Address

Preston, Idaho

Filed

May 2 1925 R. R. Cutler
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

RECEIVED
MAY 8 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Registration District No. 2449

(St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49557

Local Registrar's No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE & SINGLE, MARRIED, WID-
OWED OR DIVORCED

White

Single

(Write the word)

6. DATE OF BIRTH

April 22, 1925

(Month)

(Day)

(Year)

7. AGE

0

Yrs. 0

Mos. 0

ds.

IF LESS than 1 day how many
0 hrs. or
0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Preston, Idaho

10. NAME OF

Father

Archis Kofoed

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Mable Crockett

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Archie Kofoed

(Address)

Preston Idaho

15.

Filed

May 4

19 25

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Fibrosis of placenta

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. R. Culler

M. D.

5-4 19 25 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston

DATE OF BURIAL

April 22 19 25

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

155-226-021-433
PLACE OF BIRTH

RECEIVED
MAY 9 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS-

S

County of Franklin

City of Weston

No. _____ St. _____ Registration District No. 27 State File No. _____

Hospital _____ Primary Registration District No. 2119 Local Registrar's No. 98

FULL NAME OF CHILD _____

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

131482

(Certificate of no value without full name of child)

Sex of Child	<u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u> }	Legitimate? <u>Yes</u>	Date of birth <u>April 26, 1925</u>
					(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Albert Jensen

RESIDENCE Weston, Idaho

COLOR White AGE AT LAST BIRTHDAY 38
(Years)

BIRTHPLACE Idaho

OCCUPATION Carpenter

MOTHER
FULL MAIDEN NAME Cora McCottrough

RESIDENCE Weston, Idaho

COLOR White AGE AT LAST BIRTHDAY 29
(Years)

BIRTHPLACE Idaho

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) _____

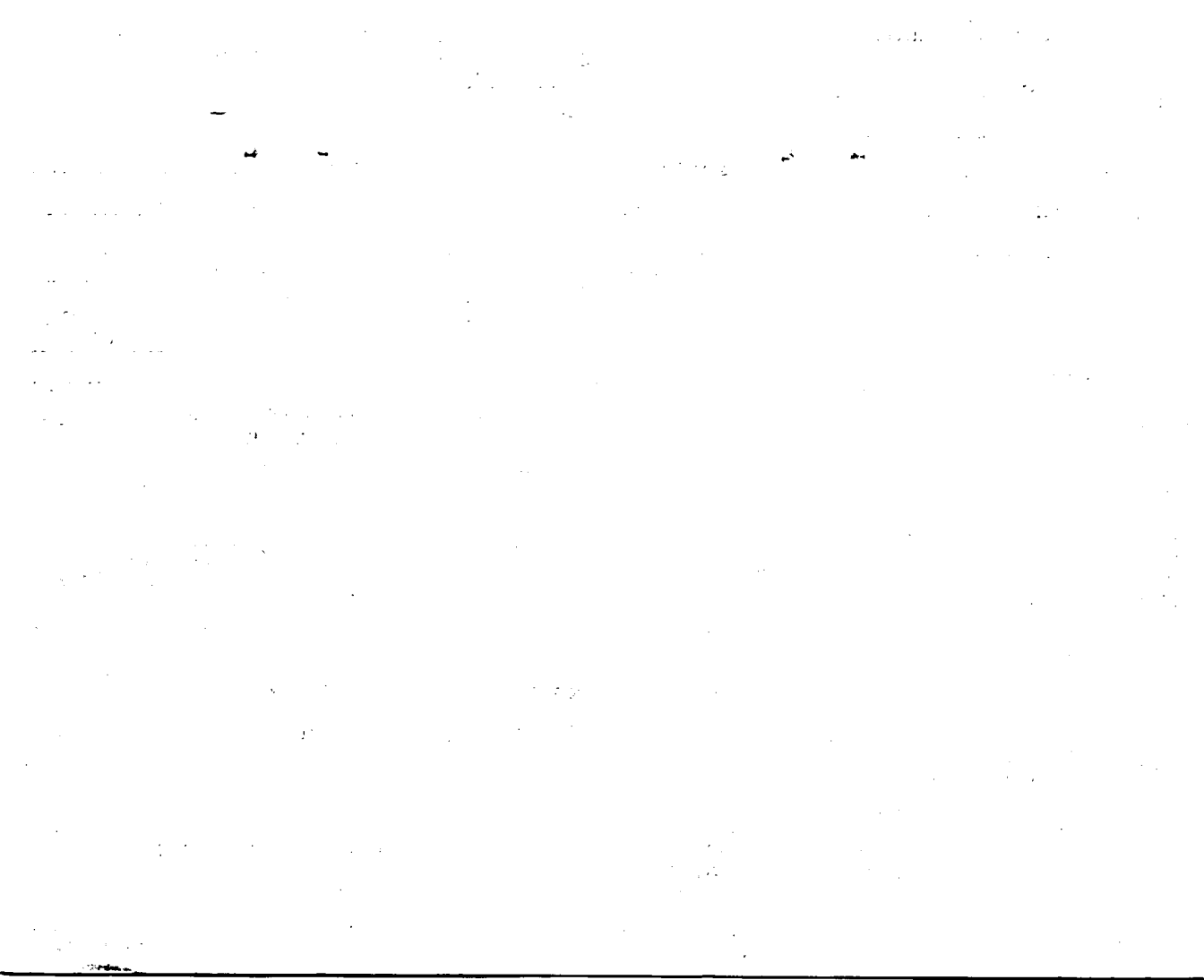
(Physician or midwife)

Address Preston, Idaho

Filed May 2 1925

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin

City of Weston

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 9 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Registration District No. 2119

St.)

2. FULL NAME Stillborn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49558

Local Registrar's No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

April 26, 1925

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

0

Yrs.

Mos.

0

ds.

0

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Weston, Idaho

10. NAME OF

Father

Albert Jensen

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Gore McCottruen

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. R. Butler Jr.

Preston, Idaho

15.

Filled May 4

1925

G. R. Butler Jr.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Undetermined was
Macerated
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

G. R. Butler Jr.

M. D.

6-4 1925

(Address)

Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Weston

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

433730-026-862
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jafferson
City of Kimberly
No. 98 St. Bureau of Vital Statistics District No. 2176 State File No. 131637
Hospital Kimberly Local Registrar's No. 52
FULL NAME OF CHILD Child born not named

(Certificate of no value without full name of child)
Sex of Child Boy Twin ✓ Triplet ✓ or other? ✓ and { Number in order of birth ✓ } Legitimate? yes Date of birth April 30 1923
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER	MOTHER
FULL NAME <u>Lafayette McCorkle</u>	FULL MAIDEN NAME <u>Carrie Gost</u>
RESIDENCE <u>Kimberly Idaho</u>	RESIDENCE <u>Kimberly Idaho</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Mo.</u>	BIRTHPLACE <u>Mo.</u>
OCCUPATION <u>Large Manager</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

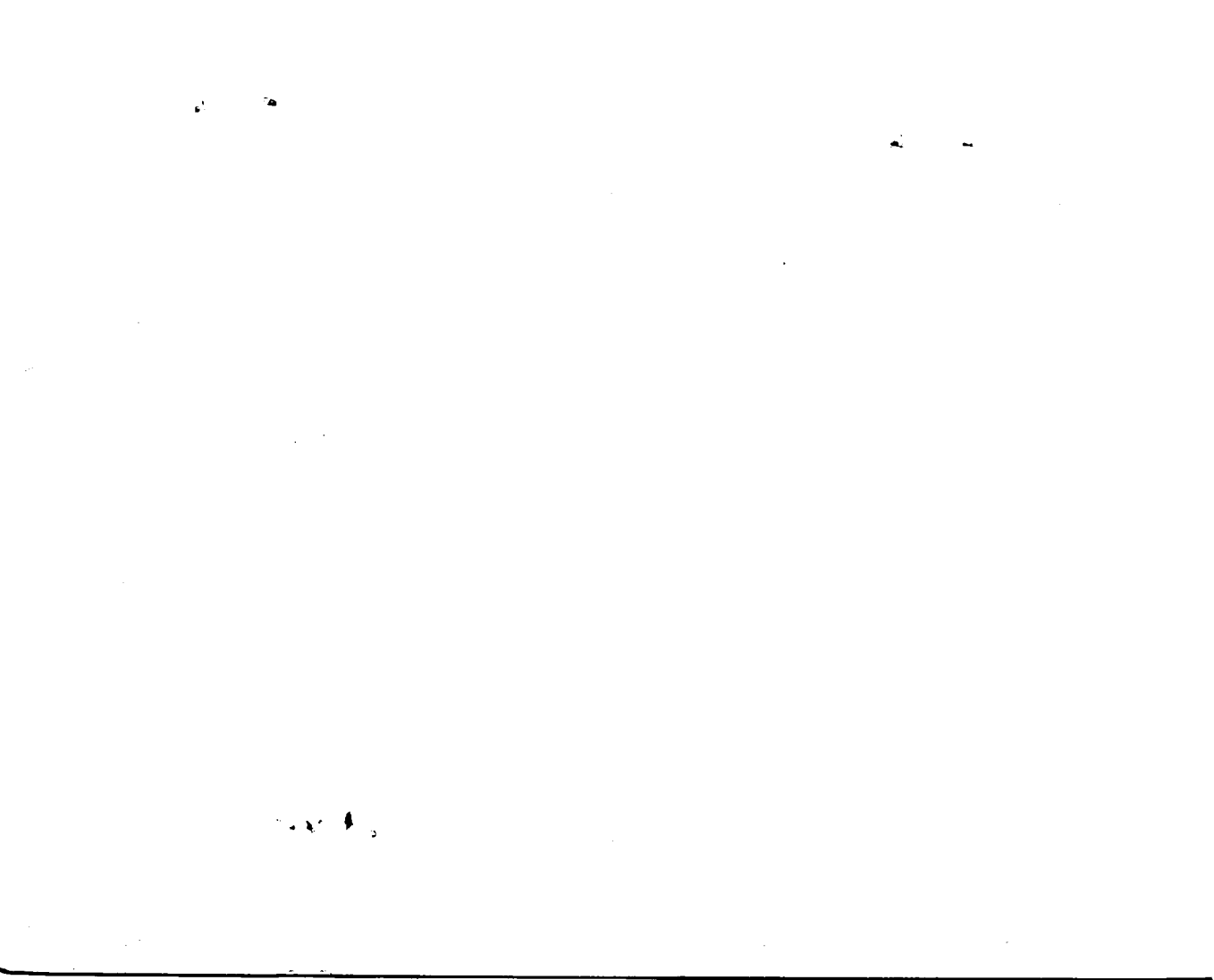
I hereby certify that I attended the birth of this child, who was { Born alive } { Stillborn } at 42 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Physician
Physician
(Physician or midwife)

Address Kimberly Idaho

Filed June 10 1925 Ray K. Fisher
Registrar.



1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 49603
Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (for employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.
that I last saw h. alive on 19.
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

713-114-026-366 *not named*
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of *Jafferson*
City of *Pirie*
No. _____ St. _____
Hospital _____ Primary Registrar's District No. *2176* State File No. *131638*
Local Registrar's No. *61*

RECEIVED
MAY 25 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child *Boy* Twin Triplet or other? *✓* and { Number in order of birth *1* Legitimate? *yes* Date of birth *April 14 1925*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth *8* Number of child of this mother now living, including present birth *6*

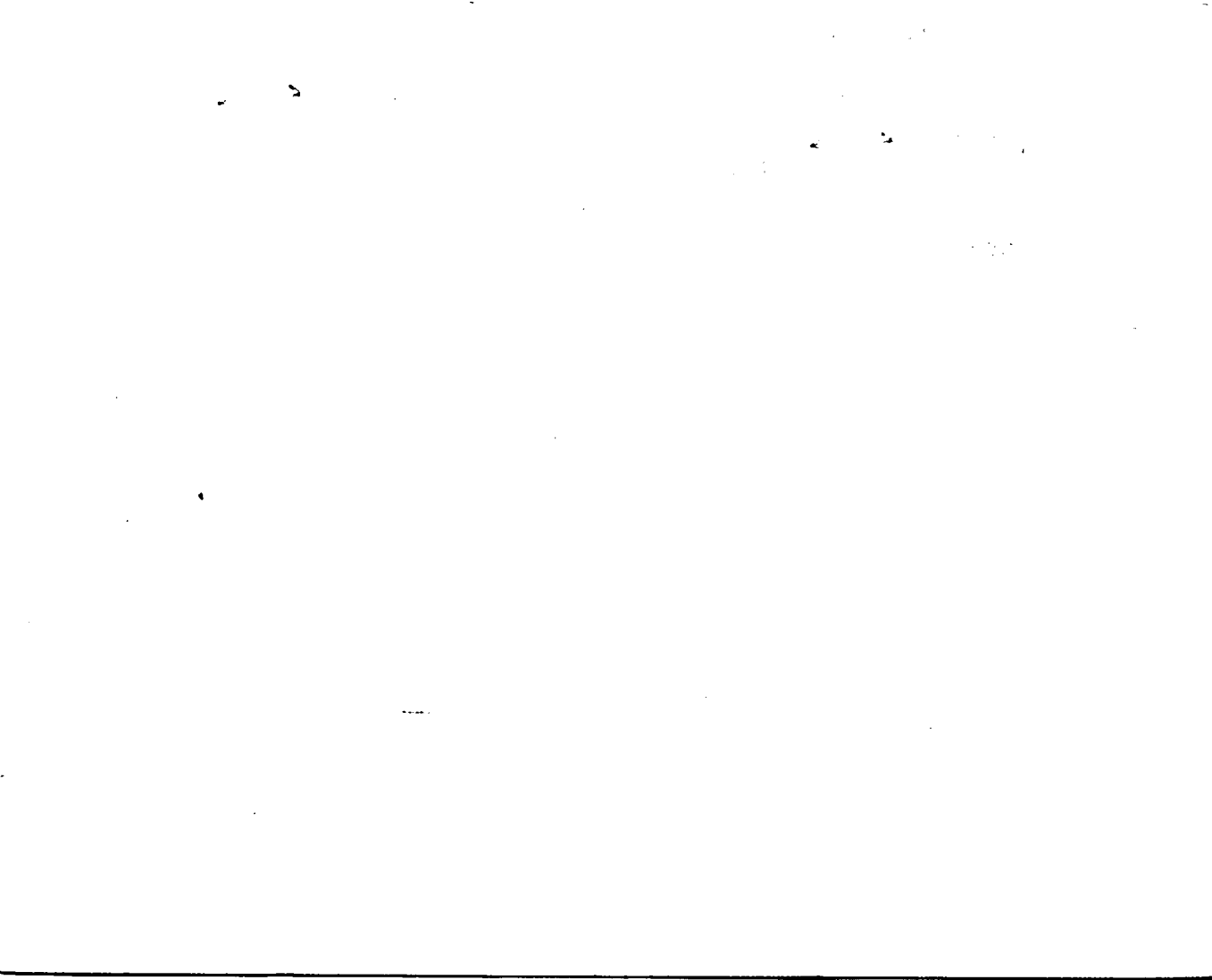
FATHER		MOTHER	
FULL NAME	<i>Willis S. Gallef</i>	FULL MAIDEN NAME	<i>Earl S. Rowder</i>
RESIDENCE	<i>Pirie Idaho</i>	RESIDENCE	<i>Pirie Idaho</i>
COLOR	<i>white</i>	COLOR	<i>white</i>
AGE AT LAST BIRTHDAY	<i>38</i> (Years)	AGE AT LAST BIRTHDAY	<i>34</i> (Years)
BIRTHPLACE	<i>Utah</i>	BIRTHPLACE	<i>Idaho</i>
OCCUPATION	<i>Grain Dealer</i>	OCCUPATION	<i>Housewife</i>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *born alive* Stillborn { at *5 P. M.* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) *Samuel Price*
Physician
(Physician or midwife)
Address *Pirie Idaho*
Filed *6-10 1925* *Kay Fisher*
Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Jefferson
City of Ririe

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

RECEIVED
MAY 5 1925
BUREAU OF VITAL STATISTICS
Register District No. 98
Primary District No. 2176
District No. 2176 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 49604
Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

April 14 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Willis S. Gallup

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Paula E. Lowder

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willis S. Gallup
Ririe Idaho

(Address)

15.

Filed

6-10-25 Rydsticker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 14 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Sam J. Bruce M. D.

Apr 19 20 (Address) Ririe Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

434227.028-264 PLACE OF BIRTH		RECEIVED JUN 10 1925 DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		S	
County of <i>Kootenai</i>		City of <i>Coeur d'Alene</i>		BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH			
No.		St.		Registration District No. <i>50</i>		State File No. <i>131685</i>	
Hospital		Primary Registration District No. <i>1051</i>		Local Registrar's No. <i>1300</i>			
FULL NAME OF CHILD <i>Baby McDonald</i> (Certificate of no value without full name of child)							
Sex of Child <i>Female</i>		Twin, Triplet or other? <i> }</i>		Number in order of birth <i> }</i>		Legitimate? <i>yes</i>	
		(To be answered only in event of plural births)				Date of birth <i>May 27 - 1925</i> (Month) (Day) (Year)	
What bactericidal solution was used in eyes?							
Number of child of this mother, including present birth <i>2</i>				Number of child of this mother now living, including present birth <i>1</i>			
FULL NAME FATHER <i>Harry E. McDonald</i>				FULL MAIDEN NAME MOTHER <i>Evelyn Bourgette</i>			
RESIDENCE <i>723-3rd Coeur d'Alene</i>				RESIDENCE <i>723-3rd Coeur d'Alene</i>			
COLOR <i>White</i>		AGE AT LAST BIRTHDAY <i>24</i> (Years)		COLOR <i>White</i>		AGE AT LAST BIRTHDAY <i>22</i> (Years)	
BIRTHPLACE <i>South Dakota</i>				BIRTHPLACE <i>Michigan</i>			
OCCUPATION <i>Salesman</i>				OCCUPATION <i>Housewife</i>			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*							
I hereby certify that I attended the birth of this child, who was <i>Stillborn</i> at <i>1130</i> A. M. on the date above stated.							
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.							
Give names added from a supplemental report., 192....							
Address <i>Coeur d'Alene Ida.</i>				Filed <i>June 4 1925</i> <i>D.D. Drena</i>			
Registrar.				Registrar.			

1990

10. The following table shows the number of people who have been convicted of a crime in the United States since 1970, by race and sex. The data are from the U.S. Department of Justice, Bureau of the Census, and the U.S. Department of Education, Office of Education Statistics.

Table 1. *Salmonella* serotypes and their associated diseases

10. The following information is available for the year ended 31 December 2014:

State Of Idaho
DEPARTMENT OF PUBLIC WELFARE

JUN 17 1925

Boise, Idaho,

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

Stillborn

Place of Birth	CITY	<u>Coeur d'Alene</u>	FILE NO.	<u>131685</u>
	ST.	<u>773-32</u>	DATE OF BIRTH	<u>5-27-25</u>
	COUNTY	<u>Kootenai</u>	SEX OF CHILD	<u>Female</u>
	FATHER	<u>Harry E. McDonald</u>	MOTHER	<u> Evelyn Bourgette</u> (Maiden Name)

RECEIVED
JUN 30 1925
BUREAU OF VITAL
STATISTICS

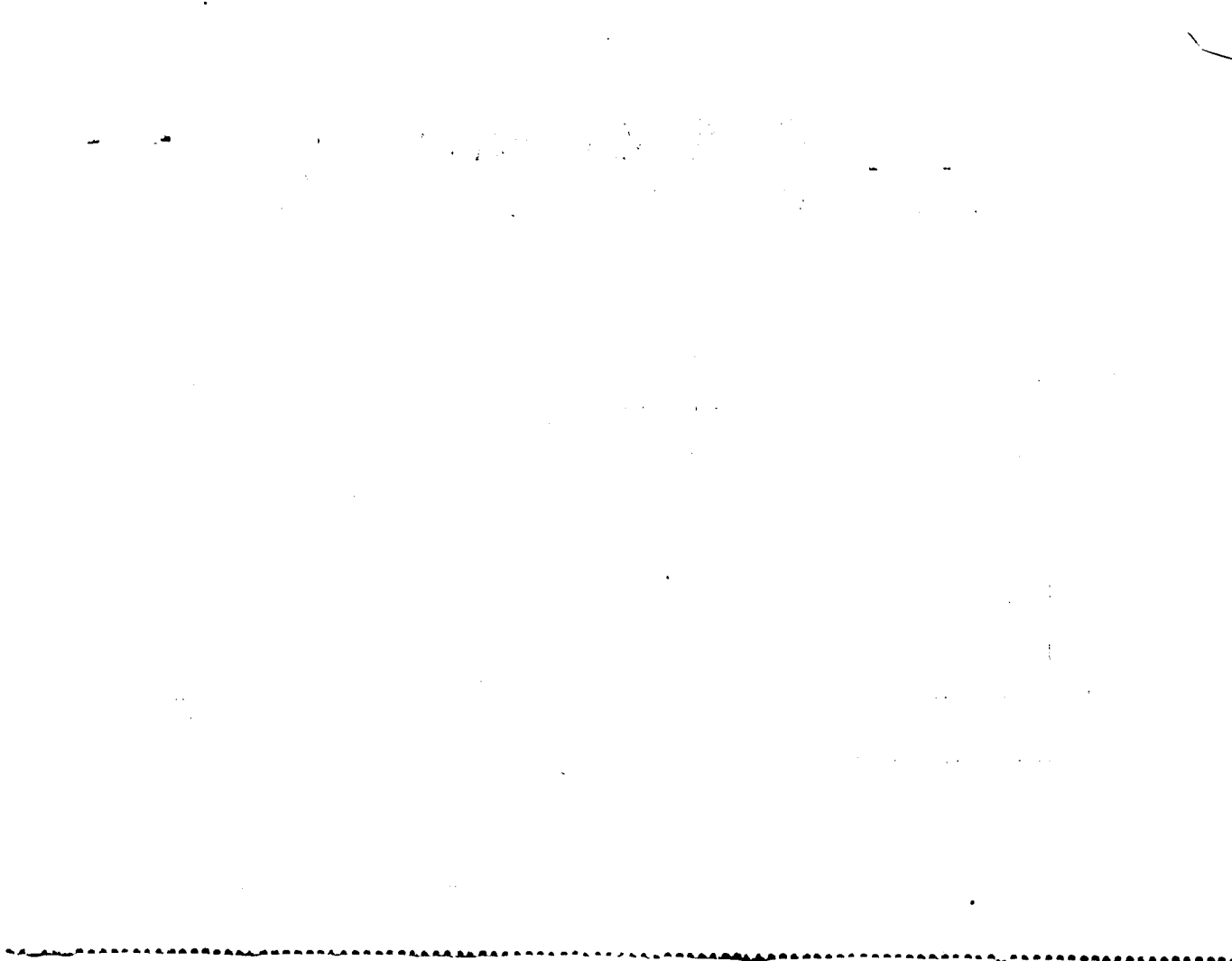
WE HEREBY CERTIFY that the child herein described has been named:

Jo Ann McDonald

Harry E. McDonald

Signature of Father or Mother.

Note: Child still born.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Boole*

City of *Coeur d'Alene*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 4 1925
BUREAU OF VITAL STATISTICS
ST. 423 Third 1030 St.

CERTIFICATE OF DEATH

Registration District No. *30*

Registration District No. *30*

St. *1030*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *49617*

Local Registrar's No. *1526*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby McDonald

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female *White* *Single*
(Write the word)

6. DATE OF BIRTH

May 27 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
— Yrs. — Mos. — ds. — hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Dakota*

10. NAME OF

Father *Harry E McDonald*

11. BIRTHPLACE

OF FATHER *So Dakota*
(State or Country)

12. MAIDEN NAME

OF MOTHER *Evelyn Bourgette*

13. BIRTHPLACE

OF MOTHER *Mich*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry E McDonald*

(Address) *Coeur d'Alene*

15.

Filed *JUN 4 1925*

19

D. D. DRENNAN, M. D.

OFFICE 210 HARDING BLOCK
COEUR D'ALENE, IDAHO
Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

May 27 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h^{er} alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. O. Martin M. D.
Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Lawrence *May 28 1925*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

913-116-828-651
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah
City of Princeton
No. # **BUREAU OF VITAL STATISTICS** District No. 65 State File No. 131713
Hospital # Primary Registration District No. 2145 Local Registrar's No. _____
FULL NAME OF CHILD Ernest Fay Rathbun

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? Yes Date of birth 4-16- 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? No

Number of child of this mother, including present birth One Number of child of this mother now living, including present birth None

FATHER
FULL NAME Fred Rathbun
RESIDENCE Princeton
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Moscow Idaho
OCCUPATION Mill hand

MOTHER
FULL MAIDEN NAME Edith Weaver
RESIDENCE Princeton
COLOR White AGE AT LAST BIRTHDAY 18 (Years)
BIRTHPLACE Princeton Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 4 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. C. Gibson
Physician
(Physician or midwife)

Address Pottatch Idaho

Filed April 23 1925 D. W. Thompson
Registrar.

2

1

4

1

2

1

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED

MAY 18 1925

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *Latah*
City of *Princeton***BUREAU OF VITAL STATISTICS**Registration District No. *65*Registration District No. *2-145*

(No.)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *49630*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Caert Fay Rathbun

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

April

(Month)

16

(Day)

1925

(Year)

7. AGE

8 Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*

9. BIRTHPLACE

(State or Country)

Princeton Idaho

10. NAME OF FATHER

Fred Rathbun

11. BIRTHPLACE OF FATHER

(State or Country)

Moscow Ida

12. MAIDEN NAME OF MOTHER

Edith Weaver

13. BIRTHPLACE OF MOTHER

(State or Country)

Princeton Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fred Rathbun

(Address)

Princeton

15.

Filed

*April 16th 1925**D. J. Thompson*

Local Registrar

16. DATE OF DEATH

April

(Month)

16

(Day)

1925

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191....., to

191.....

that I last saw him alive on

191.....

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

F. C. Gibson

M. D.

4/16/1925 (Address) *Patterson Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

April 18th 1925

20. UNDERTAKER

ADDRESS

*Parents**Princeton*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

219-231-873

County of Utah State of Utah **S**

City of Sugar City **CERTIFICATE OF BIRTH**

No. 100 **STATISTICS** 131760

Hospital Primary Registration District No. 2178 Local Registrar's No. 1088

FULL NAME OF CHILD (Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>April 21</u> 192 <u>5</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>10</u>		Number of child of this mother now living, including present birth <u>7</u>	
FATHER		MOTHER	
FULL NAME <u>Moses Barney</u>		FULL MAIDEN NAME <u>Rachel Hutchinson</u>	
RESIDENCE <u>Sugar City</u>		RESIDENCE <u>Sugar City</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 10:00 a M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. B. Rigby M.D.

(Physician or midwife)

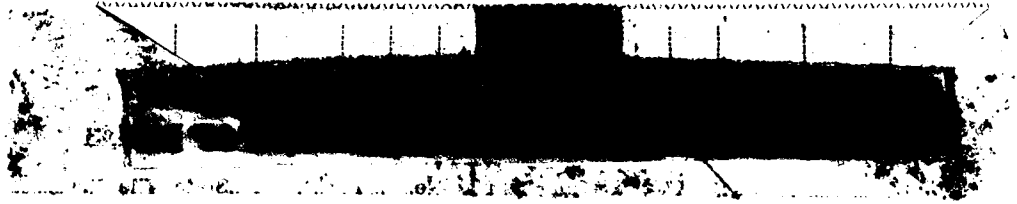
Give names added from a supplemental report. , 1925

Registrar.

Address

Filed 5/6 1925

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

442-208-029-465
PLACE OF BIRTH

RECEIVED

JUN 8 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Moscow

No. RH St.

Hospital

Registration District No. 101

File No. 131803

Primary Registration District No. 2141

Registered No. 54

FULL NAME OF CHILD

Baby Rusten

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>May 8 - 1925</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth..... Number of child of this mother now living, including present birth.....

FATHER		MOTHER	
FULL NAME	<u>Chris John Rusten</u>	FULL MAIDEN NAME	<u>Carrie Mochrie</u>
RESIDENCE	<u>Moscow, Idaho</u>	RESIDENCE	<u>Moscow, Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>35</u> (Years)	AGE AT LAST BIRTHDAY	<u>32</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Uniontown, Pa.</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was..... at 10:00 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. L. Gintman
Physician
(Physician or midwife)

Give names added from a supplemental report.
....., 19.....
Registrar.

Address Moscow, Idaho
Filed May 11 1925 M. Carothers
Registrar.



State Of Idaho

DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, JUN 17 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

Stillborn

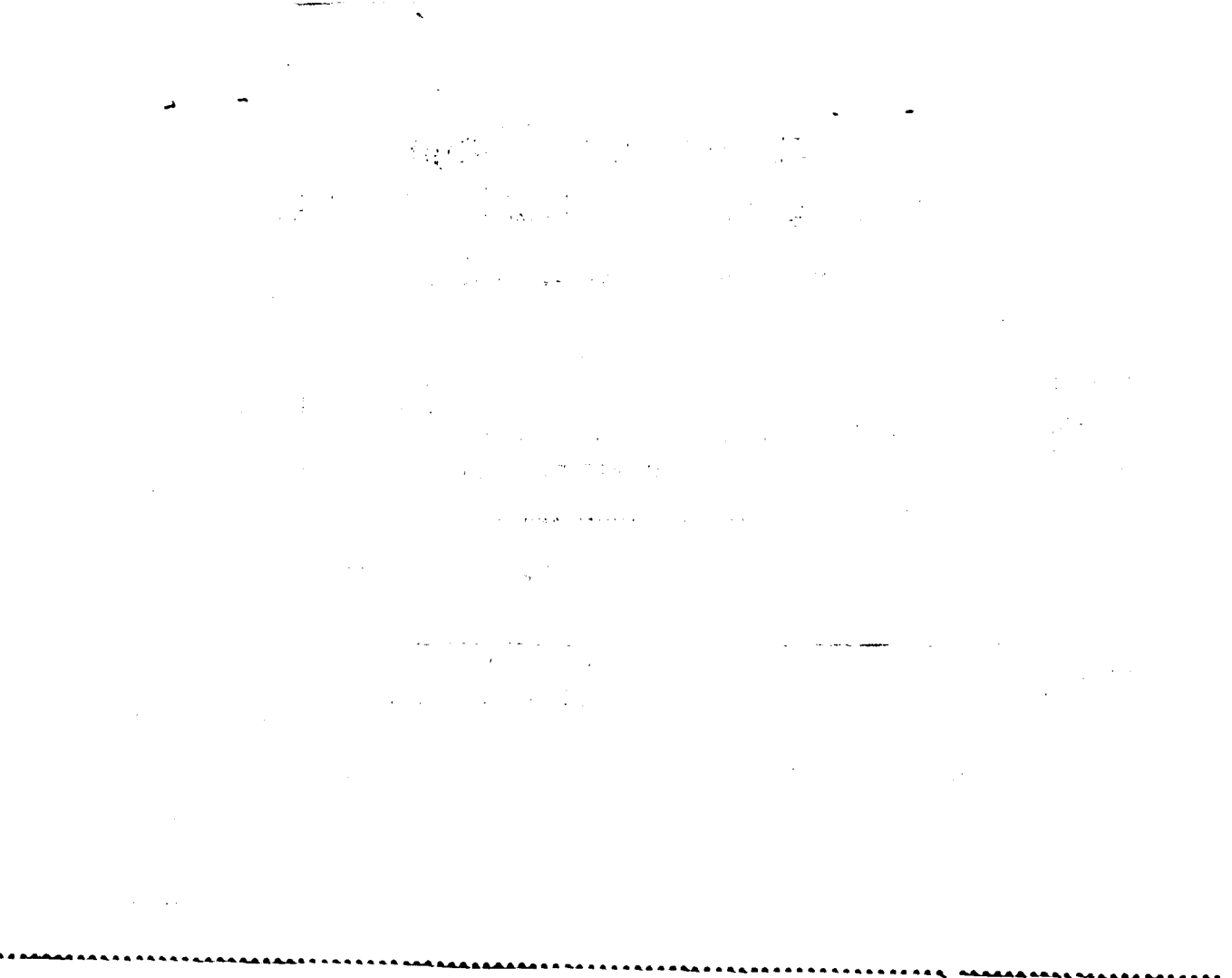
RECEIVED
JUL 6 - 1925
BUREAU OF VITAL STATISTICS

Place	CITY <i>Moscow</i>	FILE NO.	131603
of	ST.	DATE OF BIRTH	<i>May 8</i>
Birth	COUNTY <i>Latah</i>	SEX OF CHILD	<i>Female</i>
	FATHER <i>Chris Luesten</i>	MOTHER <i>Carrie Machule</i>	(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Still D. Goldie Marie Luesten

Chris Luesten
Signature of Father or Mother.



FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

JUN 8 1925 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Idaho*

City of *Moscow*

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

District No. *101*

Registration District No. *2147*

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *49643*

Registered No. *216*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Baby Duersten*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

May 8 1925
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chris J. Duersten

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Carrie Mochale

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chris Duersten

(Address)

Moscow, Idaho

15.

Filed *May 9 1925* - *M. H. Caruthers*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 8 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 8 1925* to *May 8 1925*

that I last saw him alive on *May 8 1925*

and that death occurred on the date stated above, at *10: P.M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Possibly due to a fall

(Duration) Yrs. mos. ds.

(Signed)

Chas. L. Gritman

M. D.

5/9 1925 (Address) *Moscow, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

5/10 1925

20. UNDERTAKER

F. R. Short

ADDRESS

Moscow

A stillbirth must be registered both as a birth and a death. 'The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

NOTE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 H.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

248-12-035-893
 PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

MAY 11 1925

BUREAU OF VITAL STATISTICS

S

County of Payson

City of Twinston

No. 1011, 6 St.

Registration District No. 96

State File No. 131937

Hospital

Primary Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD

Not named. Still born
 (Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 12, 1925</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? Germox

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
 FULL NAME Ralph Ignatius Kuhn
 RESIDENCE 1011 6th Twinston Idaho
 COLOR white AGE AT LAST BIRTHDAY 24 (Years)
 BIRTHPLACE Twinston Idaho
 OCCUPATION Mail carrier

MOTHER
 FULL MAIDEN NAME Theresa Marie Hickey
 RESIDENCE 1011 6th Twinston Idaho
 COLOR white AGE AT LAST BIRTHDAY 27 (Years)
 BIRTHPLACE Philadelphia Pa
 OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. D. Clark
Physician
 (Physician or midwife)

Give names added from a supplemental report.

Address Twinston Idaho

Filed May 9 1925 Susan E. Bruce
 Registrar.

Registrar.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
STATISTICAL CENTER

BRITISH BIRTH

Form of Registration District No. _____
State File No. _____

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

Sex of Child	of parent	and in other	Number	Postal	Date of birth	Year
	(To be answered in case of illegitimate)	(If different)		(Maiden)	(Month)	(Day)

Large oil barrel storage collection (left) and (right)

Number of child of this mother, including those who died

Hardinessy globular, grayish, yellowish to black, 100 mg.

10/10/1964

RECEIVED

DATE OF BIRTH: 1941
AGE AT LAST: 1941

7841 TA 30 4
7807THH

DATE: 11/18/16

84-10000

00097A

NOVA 100

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE -

on the date above stated.

His father
 dreamed that
 A small child in one the
 holes and should make the
 end of a wheel that the
 *From there was in London

(b)(7)(D) - Exemption from disclosure

121121000

• 95774238 • 24

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Nez Perce*
City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Kuhn

RECEIVED CERTIFICATE OF DEATH

MAY 11 1925
Registration District No. *96*
Registration District No. *1009*
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *49691*
Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *—* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word)

6. DATE OF BIRTH *Apr. 17 1925*
(Month) (Day) (Year)

7. AGE *—* Yrs. *—* Mos. *—* ds. IF LESS than 1 day how many *—* hrs. or *—* min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Infant.*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) *Ida*

10. NAME OF Father *Ralph Kuhn*

11. BIRTHPLACE OF FATHER (State or Country) *Idaho.*

12. MAIDEN NAME OF MOTHER *Theresa Kicky*

13. BIRTHPLACE OF MOTHER (State or Country) *Penn.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ralph Kuhn*
(Address) *Lewiston Idaho*

15. Filed *May 7 1925* *Ernest E. Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Born Apr 12 25*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *19* to *19*, that I last saw h. alive on *19*, and that death occurred on the date stated above, at *M.* The CAUSE OF DEATH* was as follows:

Stillborn
(Duration) *—* yrs. *—* mos. *—* ds.
Contributory (Secondary) *—*
(Duration) *—* yrs. *—* mos. *—* ds.
(Signed) *W. J. Clark M.D.*
Apr 15 1925 (Address) *Lewiston Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death *—* yrs. *—* mos. *—* days. State *—* yrs. *—* mos. *—* ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL *Lewiston Ida* DATE OF BURIAL *4-12 1925*

20. UNDERTAKER *Vassar Und. Co.* ADDRESS *Lewiston Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

713-224 00/432
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JUL 6 1925
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of Ada
City of Boise
No. 1 St. 1001 File No. 132042
Hospital St. Alphonsus Primary Registration District No. 199
FULL NAME OF CHILD Stillborn
(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth May 24 1925
(To be answered only in event of plural birth) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER	MOTHER
FULL NAME <u>Bruce E. Gallaher</u>	FULL MAIDEN NAME <u>Hyacinth E. McBride</u>
RESIDENCE <u>1709 Idaho St.</u>	RESIDENCE <u>1709 Idaho St.</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Laborer at sawmill</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn M.
on the date above stated. (Born alive or stillborn)

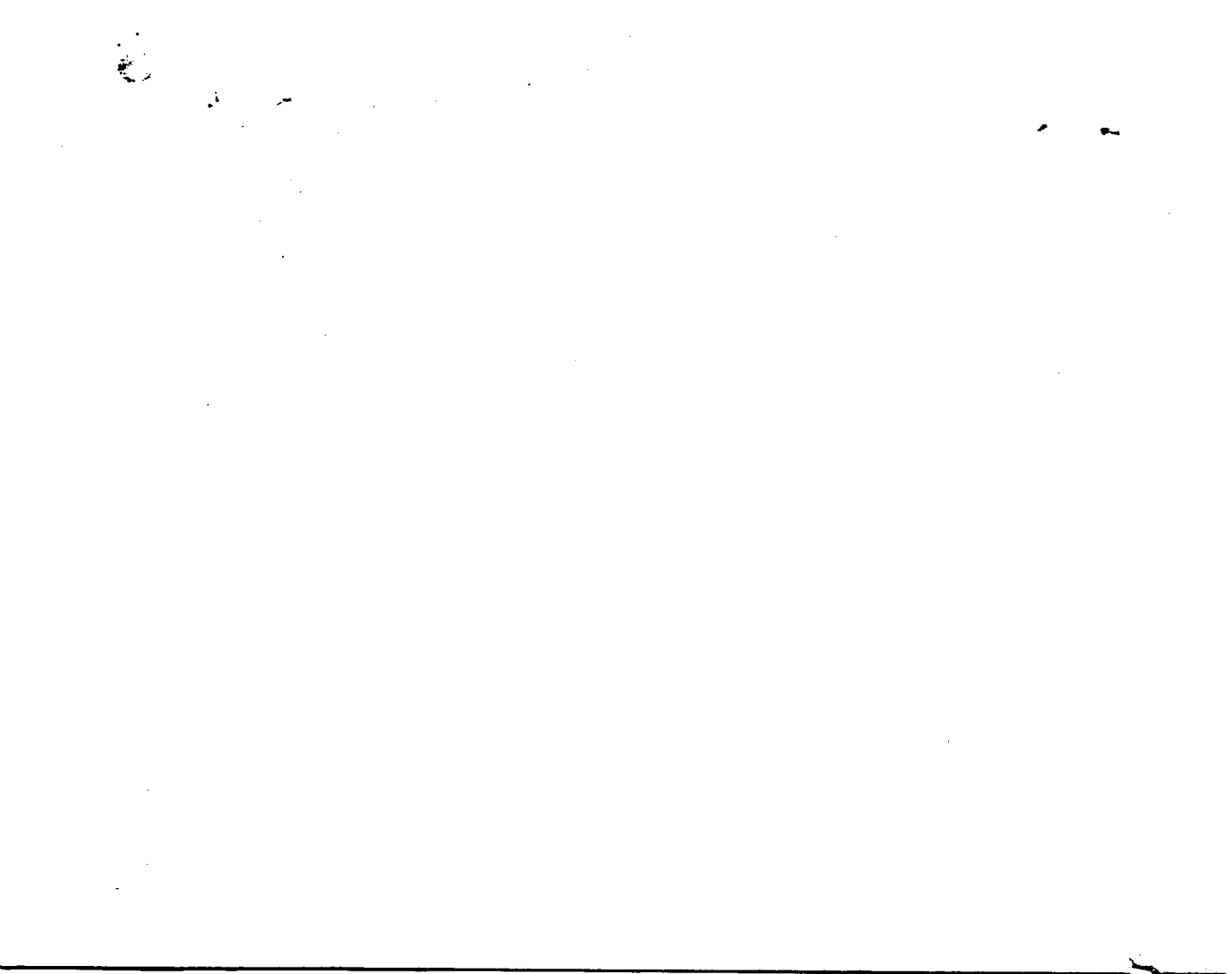
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. A. Dutton
Physician or midwife

Give names added from a supplemental report.

Address Overland Bldg. Boise
Filed 6-30-25 1925 R. D. Pratt
Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada JUL 6 1925 Registration District No. 2
City of Boise Registration District No. 1004
(No. 1004 Registration No. Boise St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Baby Gallagher

State File No. 49812
Local Registrar's No. 161
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID., OWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH May 24 1925
(Month) (Day) (Year)

7. AGE Still born IF LESS than 1 day how many
_____ hrs. or
Yrs. Mos. ds. min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Ida

10. NAME OF Father B. L. Gallagher

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Hyason M. Bude

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edna M. Bude

(Address) Boise Ida

15. Filed June 17 1925 R. H. Prich
Local Registrar

MEDICAL CERTIFICATE OF DEATH 189-6

16. DATE OF DEATH May 24 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1925 to May 24 1925
that I last saw him alive on _____ 19____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Still born

(Duration) _____ yrs. mos. ds.
Contributory (Secondary)
(Signed) E. L. Dutton M. D.
May 25 1925 (Address) Overland Bldg. - Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. mos. days. State _____ yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or usual residence Boise

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Morris Hill Cemetery 5/25/1925

20. UNDERTAKER ADDRESS
Schubert & Sons Boise
B. L. Dutton

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
169-13000-897
County of Cedar
City of Boise
No. _____ St. _____
Hospital St. Lukes
BUREAU OF VITAL STATISTICS
JUL 6 1925
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
STATE OF IDAHO
CERTIFICATE OF BIRTH
Registration District No. 2 State File No. 132077
Primary Registration District No. 1004 Local Registrar's No. 174
FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child M Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? yes Date of birth May 30 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

FATHER		MOTHER	
FULL NAME	<u>Ben. B. Jordan</u>	FULL MAIDEN NAME	<u>Vada Jones Highfill</u>
RESIDENCE	<u>Boise, Ida</u>	RESIDENCE	<u>Boise, Ida</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>64</u> (Years)	AGE AT LAST BIRTHDAY	<u>33</u> (Years)
BIRTHPLACE	<u>Kansas</u>	BIRTHPLACE	<u>Arkansas</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>W. W.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 8:40 M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Wm. B. Pratt

(Physician or midwife)

Address Boise, Ida

Filed 6-30-25 1925

Registrar.

Registrar.

[illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME

Father

11. BIRTHPLACE

OF FATHER

(State or Country)

12. MAIDEN NAME

OF MOTHER

13. BIRTHPLACE

OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filled

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

2. FULL NAME

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection, with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
219 121 00 962		DEPARTMENT OF PUBLIC WELFARE	
County of <u>Ada</u>		BUREAU OF VITAL STATISTICS	
City of <u>Boise</u>		JUL 6 1925	
No. <u>1217 Leadville</u>		BUREAU OF VITAL STATISTICS	
St. <u>Boise</u>		CERTIFICATE OF BIRTH	
Hospital		District No. <u>1</u> State File No. <u>132085</u>	
Primary Registration District No. <u>1007</u>		Local Registrar's No. <u>217</u>	
FULL NAME OF CHILD			
<input checked="" type="checkbox"/> Certificate of no value without full name of child			
Sex of Child	<u>male</u>	Twin Triplet or other?	<u>and</u> { Number in order of birth
		(To be answered only in event of plural births)	
Legitimate?	<u>yes</u>	Date of birth	<u>May 21</u> 192 <u>5</u>
		(Month)	(Day) (Year)
What bactericidal solution was used in eyes? <u>—</u>			
Number of child of this mother, including present birth <u>3</u>		Number of child of this mother now living, including present birth <u>2</u>	
FULL NAME	FATHER <u>Earl Sailor</u>	FULL MAIDEN NAME	MOTHER <u>Mabel Rose</u>
RESIDENCE	<u>1217 Leadville St. Boise Idaho</u>	RESIDENCE	<u>1217 Leadville St. Boise Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>23</u> (Years)	AGE AT LAST BIRTHDAY	<u>23</u> (Years)
BIRTHPLACE	<u>Meridian Idaho</u>	BIRTHPLACE	<u>Boise Idaho</u>
OCCUPATION	<u>City Fireman</u>	OCCUPATION	<u>Housewife</u>
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:			
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>4 P.</u> M. on the date above stated.			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.			
Give names added from a supplemental report.			
<u>192</u>			
Registral.		Registral.	

(Signature) P. P. French M.D.

(Physician or midwife)

Address 415 Overland Bldg. Boise Idaho

Filed 6-30 1925 P. N. Pratt

Registral.

RECEIVED
BUREAU OF VITAL STATISTICS
JAN 10 1913
No. 13208

RECEIVED
BUREAU OF VITAL STATISTICS
JAN 10 1913
No. 13208

Primary Registration District No. *13208*
Hospital *St. Louis*
City *St. Louis*
County *St. Louis*

Full Name of Child *John*
Sex *Male*
Date of Birth *Jan 10 1913*
Place of Birth *St. Louis*
Occupation *None*

What particular notation was used in entry
Number of child of this mother including present birth *3*
Number of child of this mother including present birth *3*
MOTHER FULL NAME *John*
FATHER FULL NAME *John*

RESIDENCE *St. Louis*
COLOR *White*
AGE AT LAST BIRTHDAY *10*
BIRTHPLACE *St. Louis*

OCCUPATION *None*
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of the child, who was *born* at *St. Louis* on the date above stated.

When there was no attending physician or midwife, then the father, husband or other person should make this return. A statement that the child is one that neither prescribes nor shows other evidence of life after birth.

(Give names signed from a supplemental report.)
Physician or Midwife *John*
Date *Jan 10 1913*

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

JUN 4 1925

Registration District No.

BUREAU OF VITAL STATISTICS

Registration District No.

(No. 1217 Leadville Ave.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Single
(Write the word)

6. DATE OF BIRTH

May 21 1925
(Month) (Day) (Year)

7. AGE

Still Born

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father

11. BIRTHPLACE

OF FATHER

(State or Country)

12. MAIDEN NAME

OF MOTHER

13. BIRTHPLACE

OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

5-29-25

R. V. Pratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 21 1925 to May 21 1925

that I last saw him alive on May 21 1925

and that death occurred on the date stated above, at —

The CAUSE OF DEATH* was as follows:

Still Born

Contributory

(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) P. P. French M. D.

19 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

Boise Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 5/22 1925

20. UNDERTAKER

ADDRESS

Schubert & Sidenfaden Boise Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

356 118 003 897
PLACE OF BIRTHCounty of BannockCity of Bancroft

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD

RECEIVED

JUL 8 1925

BUREAU OF VITAL
STATISTICS

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

File No. 132099Primary Registration District No. 2161 Registered No. 153✓ Baby Lewis

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of Birth <u>6-18-1925</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

FULL NAME FATHER Le Roy Milford LewisRESIDENCE BancroftCOLOR White AGE AT LAST BIRTHDAY 26 (Years)BIRTHPLACE IdahoOCCUPATION MechanicFULL MAIDEN NAME MOTHER Pearl HigginsonRESIDENCE BancroftCOLOR White AGE AT LAST BIRTHDAY 25 (Years)BIRTHPLACE IdahoOCCUPATION HousewifeNumber of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 12.30 P.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) St. G. Fitz

(Physician or midwife)

Given names added from a supplemental report.

19

Address Bancroft, IdahoFiled July-1-1925

Registrar

Registrar Mrs. E. G. Fitz

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

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U. S. DEPARTMENT OF JUSTICE

RECEIVED

1. PLACE OF DEATH

County of Bannock
City of Bancroft

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single (Write the word.)

6. DATE OF BIRTH

6-18-1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

LeRoy Wilbur Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Pearl Higginson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 19Mrs. J. J. Fitz
Local RegistrarRECEIVED
JUL 8 1925
BUREAU OF VITAL STATISTICS
Registration District No. 84
Registration District No. 2161State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 49843
Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6-18-1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn. Unknown.
Probably caused by
lightning shock, mother
refused, dazed for yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bancroft

DATE OF BURIAL

6-18-1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

819-121003533
County of *Bannock*

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

S

BUREAU OF VITAL STATISTICS

CITY OF *Pocatello* RECEIVED JUN 30 1925 BUREAU OF VITAL STATISTICS

No. *28* St. *Pocatello* State File No. *132110*

Hospital *Pocatello General* Primary Registration District No. *2161* Local Registrar's No. *7007*

FULL NAME OF CHILD *Harper*

(Certificate of no value without full name of child)

Sex of Child *Male* Twin Triplet or other? *and* Number in order of birth *1* Legitimate? *yes* Date of birth *April 21, 1925*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? *none used*

Number of child of this mother, including present birth *3* Number of child of this mother now living, including present birth *1*

FATHER
FULL NAME *Thomas Harper*
RESIDENCE *Popay, Idaho*
COLOR *White* AGE AT LAST BIRTHDAY *42* (Years)
BIRTHPLACE *England*
OCCUPATION *Farmer*

MOTHER
FULL MAIDEN NAME *Sarah Ellis*
RESIDENCE *Popay, Idaho*
COLOR *White* AGE AT LAST BIRTHDAY *39* (Years)
BIRTHPLACE *Pleasant View*
OCCUPATION *Housewife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* at *930 P.* M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) *John M. Wasth M.D.*
Physician -
(Physician or midwife)

Address *McCaum, Idaho*

Filed *6/1 1925* Registrar.

Registrar.

Registrar.

100-443881-1

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

MAY 18 1925

Registration District No.

2141

(No. General Hospital St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

49398

Local Registrar's No.

4600

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

white

Infant
(Write the word)

6. DATE OF BIRTH

April 21

(Month)

1925
(Year)

7. AGE

Stillborn

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF FATHER

Tom Harper

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah A. Ellis

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Tom Harper

(Address)

Lafayette, Ida.

15.

Filed

7/24

1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 21
(Month)

(Day)

1925
(Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-21 1925 to 4-21 1925, that I last saw her dead 4-21 1925, and that death occurred on the date stated above, at 9:00 M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Long difficult labor

(Duration)

yrs.

mos.

ds.

(Signed)

W.W. Brotherton, M.D.

4-24-1925

(Address)

Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cydon, Utah

April 26, 1925

20. UNDERTAKER

ADDRESS

Schumacher & Co.

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia;** **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles;** **Whooping cough;** **Chronic valvular heart disease;** **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.;** **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning;** **struck by railway train—accident;** **Revolver wound of head—homicide;** **Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH 814-130003-319
County of Bannock
City of Pocatello
No. 1435 N. Gay St. Registration District No. 28 State File No. 132113
Hospital V Primary Registration District No. 2141 Local Registrar's No. 2049
FULL NAME OF CHILD No Name

RECEIVED
JUN 30 1925
BUREAU OF VITAL STATISTICS
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

Sex of Child Male Twin Triplet or other? } and { Number in order of birth 1 Legitimate? yes Date of birth 5-30-1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Ray Wm. Hadley
RESIDENCE Pocatello Idaho
COLOR wht AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Utah
OCCUPATION Car Inspector

MOTHER
FULL MAIDEN NAME Violet Carlson
RESIDENCE same
COLOR wht AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Scrubborn at 12: M M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) D. C. Ray

(Physician or midwife)

Address Pocatello, Idaho

Filed 4 1925

Registrar.

Registrar.

Details of the investigation are being furnished to the FBI and the State Department.

PLACE OF BIRTH

RECEIVED
JUL 10 1952
BUREAU OF PRISON STATISTICS
DEPARTMENT OF PUBLIC WELFARE
STATE OF INDIANA

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-14-2013 BY 60322 UCBAW

Registration No.

Reference: No.

FILED TO FILE 7 JAN 19

(Certificate of no value without full name of child)

[illegible]

1977-1978 and 1979-1980

Number of child of this mother including present birth

None of the child of this mother now living, including deceased

NAME
FOL

РЕЗУЛТАТ

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RENTOM

09-06-2008

24

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COLON

AGE AT LAST
YACHTING

NOTES

TRAITAZDA
TADITRIB

304151

30494718

NOTATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

Cite names added from a typographical report showing other evidence of life after death. Death is one that neither presumes nor etc. should make this report. A physician or minister from the latter. Hoped to see when there was no attending physician on the date above stated. I hereby certify that I attended the first of

(S10100412)

(Physician or Midwife)

ANOTHA

କେମିତି

L. Sei

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bern*

City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Hadley

RECEIVED
JUL 17 1925
BUREAU OF VITAL STATISTICS

District No. *28*

Primary Registration District No. *2101*

(No. *1425* No. *Sanfield*)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *50210*

Local Registrar's No. *4628*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Infant
(Write the word)

6. DATE OF BIRTH

May 30 1925
(Month) (Day) (Year)

7. AGE

Premature
Stillborn
Yrs. mos. ds.

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Pocatello, Ida.

10. NAME OF
Father

J. W. Hadley

11. BIRTHPLACE
OF FATHER

(State or Country)

Hilland, Utah.

12. MAIDEN NAME
OF MOTHER

Viola Carlson.

13. BIRTHPLACE
OF MOTHER

(State or Country)

Clifton, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Hadley
Pocatello, Ida.

15.

Filled

41 1925

J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

189.6

16. DATE OF DEATH

May 30 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19. to *May 31 1925*

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Died in uterus 8 days
previous to birth. cord
propped around neck
Sixth month gestation*
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. C. Ray M. D.
6-1 1925 (Address) *Pocatello.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View *June 1 1925*

20. UNDERTAKER

ADDRESS

Schumacher & Hall Pocatello Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
3861130031253
County of Junnoch
City of Pocatello
No. 28 St. Registrar District No. 241 State File No. 132115
Hospital Pocatello Primary Registration District No. 7047 Local Registrar's No. 7047
BUREAU OF VITAL STATISTICS
JUN 30 1925
CERTIFICATE OF BIRTH
FULL NAME OF CHILD Earl A. Thomson
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 5-30 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0
FATHER FULL NAME Earl Alexander Thomson FULL MAIDEN NAME Emma Florence Kelly
RESIDENCE Pocatello Idaho RESIDENCE same
COLOR wht AGE AT LAST BIRTHDAY 25 COLOR wht AGE AT LAST BIRTHDAY 20
(Years) (Years)
BIRTHPLACE Idaho BIRTHPLACE Idaho
OCCUPATION Dairy man OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at Pocatello on the date above stated. 1:30 P. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Pocatello Idaho

Filed 4/1 1925

Registrar.

Registrar.

RECEIVED BY THE BUREAU OF VITAL STATISTICS
 JUN 10 1935
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF PUBLIC HEALTH
 STATE OF IDAHO
 PLACE OF BIRTH

RECEIVED BY THE BUREAU OF VITAL STATISTICS
 JUN 10 1935
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF PUBLIC HEALTH
 STATE OF IDAHO
 PLACE OF BIRTH

County of _____
 City of _____
 No. _____
 Hospital _____
 Primary Registration District No. _____
 Local Registrar's No. _____
 FULL NAME OF CHILD _____
 Sex of Child _____
 Date of Birth _____
 (To be answered only in case of twins)

Want hospital notation was used in case _____
 Number of child of this mother, including present birth _____
 Name of child of this mother now living, including present birth _____
 FATHER
 FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____
 MOTHER
 FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was _____
 on the date above stated.
 When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
 Give names added from a supplemental report.

(Signature) _____
 (Physician or midwife)

Filed _____
 Address _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Peru*City of *Peru*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED DATE OF DEATH

Registered No. *14825*

BUREAU OF VITAL STATISTICS

District No. *241* St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. *20219*Local Registrar's No. *4696*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word)

6. DATE OF BIRTH

May 31 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
X hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Earl Thompson

11. BIRTHPLACE OF FATHER

(State or Country) *Utah*

12. MAIDEN NAME OF MOTHER

Emma Kelly

13. BIRTHPLACE OF MOTHER

(State or Country) *Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *Peru, Idaho*

15.

Filed

June 1 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 31 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *May 31 1925* to *May 31 1925*that I last saw him alive on *19* M. and that death occurred on the date stated above, at *19* M.

The CAUSE OF DEATH* was as follows:

Death in utero or Stillborn

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 1 1925 (Address) *Peru, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Peru, Idaho *June 1 1925*

20. UNDERTAKER

ADDRESS

W. E. Budd & Co. *Peru, Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

756110004785
PLACE OF BIRTH

County of Bear Lake

City of Montpelier

No. _____ St.

Hospital _____

FULL NAME OF CHILD _____

RECEIVED

JUL 3 1925

BUREAU OF VITAL

STATISTICS

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-22a-3-15-12

S

File No.

132160

Primary Registration District No. 2136

Registered No. _____

Sex of Child	Boy	Twin Triplet or other?	{ and } Number in order of birth	Legitimacy	Yes	Date of Birth	2-10-25
(To be answered only in event of plural births)				met	(Month)	(Day)	(Year)

FULL NAME	FATHER
RESIDENCE	Montpelier
COLOR	White
BIRTHPLACE	Montpelier
OCCUPATION	Farmer

FULL MAIDEN NAME	MOTHER
RESIDENCE	Montpelier
COLOR	White
BIRTHPLACE	Montpelier
OCCUPATION	Wife

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still Born at 4 A.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DR G. F. ASHLEY.

(Signature)

Montpelier

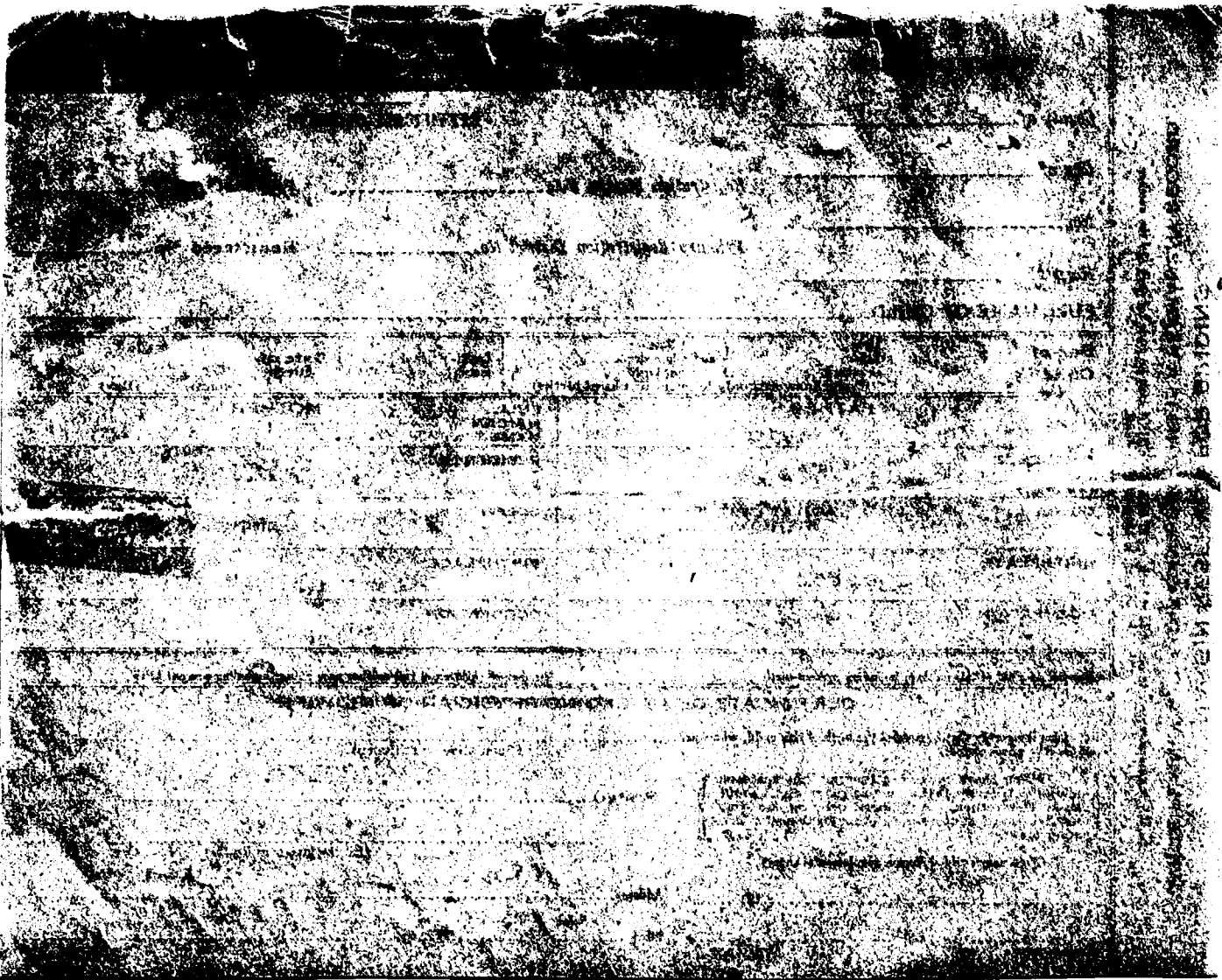
(Physician or midwife)

Given names added from a supplemental report

Address

Filed

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

RECEIVED

Registration District No. 59

County of Butte

JUL 6 1925

Registration District No.

City of Arco

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant George (Infant)

File No. 49908

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH.

5
(Month)16
(Day)25
(Year)

7. AGE

IF LESS than 1 day
how many.....hrs. or
.....min.?

16. DATE OF DEATH

5
(Month)16
(Day)1925
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h..... alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) R. H. Robinson M. D.

19 (Address) Arco

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arco.

May 19, 1925

20. UNDERTAKER

ADDRESS

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Heggie M. George

(Address)

Arco Ida

15.

Filed

July 3

1925

D. E. Dignan

Local Registrar

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

319-110004'366

County of Bear LakeCity of Dingle

STATE OF IDAHO

RECEIVED DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

JUL 3 1925

BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH

S

132162

No. _____ St. _____ Registration District No. 52 State File No. 256

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of
Child BoyTwin
Triplet
or other?} and { Number
in order
of birth
(To be answered only in event of plural births)Legiti-
mate? YesDate of
birth Jan 10 1925
(Month) (Day) (Year)What bactericidal solution was used in eyes? J. Arg

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth ENFULL
NAME

FATHER

J. E. LarocoFULL
MAIDEN
NAME

MOTHER

Mary S. Cook,

RESIDENCE

Dingle

RESIDENCE

Dingle

COLOR

WAGE AT LAST
BIRTHDAY 37
(Years)

COLOR

WAGE AT LAST
BIRTHDAY 30
(Years)

BIRTHPLACE

Dingle

BIRTHPLACE

Dingle

OCCUPATION

Farmer

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born alive at _____ A m. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address [Address]Filed 6/30 1925

Registrar.

Registrar.

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR AND THE ATTENDING PHYSICIAN OR MIDWIFE. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY THE REGISTRAR OR THE ATTENDING PHYSICIAN OR MIDWIFE AFTER THE CHILD HAS BEEN BORN. IT IS NOT VALID IF SIGNED BY THE REGISTRAR OR THE ATTENDING PHYSICIAN OR MIDWIFE BEFORE THE CHILD HAS BEEN BORN. IT IS NOT VALID IF SIGNED BY THE REGISTRAR OR THE ATTENDING PHYSICIAN OR MIDWIFE AFTER THE CHILD HAS BEEN BORN AND BEFORE THE CHILD IS TWO YEARS OLD. IT IS NOT VALID IF SIGNED BY THE REGISTRAR OR THE ATTENDING PHYSICIAN OR MIDWIFE AFTER THE CHILD HAS BEEN BORN AND BEFORE THE CHILD IS TWO YEARS OLD.

Register. Filed. Address. 1921.

When there was no attending physician or midwife then the father, grandfather, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

I hereby certify that I attended the birth of this child, who was (Stillborn / ALIVE) on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

OCCUPATION *Farmer* BIRTHPLACE *Indiana* COLOR *W* AGE AT LAST BIRTHDAY *37* (Years)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

892-107005-569
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Benevolence
City of St. Maries
No. 138-8th St. Registration District No. 32 State File No. 132229
Hospital Platt's Primary Registration District No. 1849 Local Registrar's No. 35
FULL NAME OF CHILD Henry V. Hibbeln Jr.
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? } and } Number in order of birth 1 Legitimate? yes Date of birth May 7 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Borogel

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Henry Hibbeln
RESIDENCE Calden, Idaho
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Ind.
OCCUPATION Logging

MOTHER
FULL MAIDEN NAME Ana Nord
RESIDENCE Calden, Idaho
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Duluth, Minn.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Owen N. Platt, M.D.

(Physician or midwife)

Address St. Maries, Idaho

Filed June 24 1925

Registrar.

Registrar

DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRIES
UNITED STATES OF AMERICA

DEVELOPMENT

SECRET

NO INTEREST

2501 2400

in vain

SECRET

Company Registration Number: 108091

Inspection

Certificate of no value without full name of officer

-----**CLINT TO ARNOLD LHM**-----

[illegible]

Page 31 been now notified. Information that it

A number of children in this school were having trouble in reading.

Number of eggs in the nest, including brood birds

RENTON

REPLY

NAME

NAME
MADSEN
FULL

ଅନୁମତିପ୍ରାପ୍ତ

5. 190199M

03-00

YACHTING

100

BIRTHPLACE

王德山、王德山、王德山

MOGA90300

HOZMUNDO

• CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE •

...and I attended the birth of this child, who was

(94734448)

[illegible]

(Physician or midwife)

883761A

100-443887-100

Page 10

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bennah
City of St. Marcus

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

RECEIVED
JUN 24 1925
BUREAU OF VITAL STATISTICS

Registration District No. 32
Primary Registration District No. 2049
St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49858
Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male white OWED OR DIVORCED
(Write the word)

6. DATE OF BIRTH

May 7 1925
(Month) (Day) (Year)

7. AGE

Still Born
IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds. min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF Father

Henry Hibbeln

11. BIRTHPLACE OF FATHER

(State or Country) Nebr.

12. MAIDEN NAME OF MOTHER

Annie Ward

13. BIRTHPLACE OF MOTHER

(State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Hibbeln
(Address) of Calder

15. May. 7 1925 Desmerager
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1925 to May 7 1925,
that I last saw h— alive on — 19—, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Still Born.

(Duration) yrs. mos. ds.
Contributory Dead in utero 10 days
(Secondary) decompressed fetus.
(Duration) yrs. mos. ds.

(Signed) Ed. Peet M. D.
May 7 1925 (Address) St. Marcus

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn May 7 1925
21. UNDERTAKER Mitchell & Merager ADDRESS St. Marcus

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
713 209 006 759
County of Bingham
City of Blackfoot
No. Ward #4 St. Registration District No. 121 State File No. 132266
Hospital _____ Primary Registration District No. 2007 Local Registrar's No. 200
FULL NAME OF CHILD Betty Louise Packham

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>June 9 1925</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME J. Wallace Packham

RESIDENCE Blackfoot, Idaho

COLOR White AGE AT LAST BIRTHDAY 20
(Years)

BIRTHPLACE Utah

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Loeta Gertsch

RESIDENCE Blackfoot, Idaho

COLOR White AGE AT LAST BIRTHDAY 20
(Years)

BIRTHPLACE Idaho

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address _____

Filed July 6 1925

Registrar.

Registrar.

THIS CERTIFICATE IS TO BE USED IN CONNECTION WITH THE BIRTH RECORDS OF THE STATE OF ALABAMA. IT IS TO BE FILED IN THE BIRTH RECORDS OF THE STATE OF ALABAMA. IT IS TO BE FILED IN THE BIRTH RECORDS OF THE STATE OF ALABAMA.

2

CERTIFICATE OF BIRTH

County of Blount State of Alabama

Primary Residence District No. 1 Local Health District No. 1

Birth Name of Child Betty Louise Jackson

(Certificate of no value without registration of child)

Sex of Child Female Race White Date of Birth 1930 Month 10 Day 10 Year 1930

What particular relation was used in case?

Number of child of this mother, including present birth 1

NAME FULL NAME Betty Louise Jackson

FATHER NAME FULL NAME William Jackson

RESIDENCE Blount, Alabama

COLOR White AGE AT LAST BIRTHDAY 10

BIRTHPLACE Alabama OCCUPATION Lawyer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date above stated.

(Signature) Dr. W. H. H. H.

Physician or midwife

Address Blount, Alabama

Filed 1930

1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **49869**
Registered No. **68**

1. PLACE OF DEATH

County of **Bingham** Registration District No. **121**
City of **Blackfoot** Registration District No. **2194** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Betty Lou Padgham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female **White** **Single**
(Write the word.)

6. DATE OF BIRTH.

June 9 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

(State or Country)

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

(State or Country)

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Mr. Fred Gartsch**
(Address) **Blackfoot, Idaho**

15.

Filed **June 10 1925** **Mr. Walter E. Padgham**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 9 1925
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from **June 9 1925** to **June 9 1925**

that I last saw **her** on **June 1925** and that death occurred on the date stated above, at **—** M.

The CAUSE OF DEATH* was as follows:

Pneumonia - 7 mo.
(Duration) **7** yrs. **—** mos. **—** ds.

Contributory
(Secondary)

(Signed) **H. H. H. H. H.** M. D.

6/9 1925 (Address) **Blackfoot, Idaho**

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Grove City, Idaho **191**

20. UNDERTAKER ADDRESS

None employed

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
236-108006713
County of Bingham
City of Springfield

RECEIVED

JUL 8 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. _____ St. _____ Registration District No. 121 State File No. 132267
Hospital _____ Primary Registration District No. 144 Local Registrar's No. 179
FULL NAME OF CHILD James Stone

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>June 8 1925</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME
Robert H. Stone

RESIDENCE
Springfield, Idaho

COLOR White AGE AT LAST BIRTHDAY 44
(Years)

BIRTHPLACE Utah

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME
Laura Jackman

RESIDENCE
Springfield, Idaho

COLOR White AGE AT LAST BIRTHDAY 38
(Years)

BIRTHPLACE Utah

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3.30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. W. Mitchell

(Physician or midwife)

Address _____

Filed July 6 1925

Registrar.

Registrar.

[Illegible text]

SECRET

INSTITUTE OF BIOLOGY

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 01-18-01 BY 60322 UCBAW

1. Name of the person: John Doe
 2. Date of birth: 12/15/1945
 3. Sex: Male
 4. Race: White
 5. Height: 5' 10"
 6. Weight: 180 lbs
 7. Eyes: Blue
 8. Hair: Brown
 9. Markings: None
 10. Address: 123 Main St, Springfield, IL 62761
 11. Telephone: (312) 555-1234
 12. Occupation: Teacher
 13. Education: High School Graduate
 14. Marital Status: Married
 15. Number of children: 2
 16. Name of spouse: Jane Doe
 17. Name of children: Michael, Sarah
 18. Date of marriage: 08/10/1968
 19. Date of last contact: 01/15/1970
 20. Date of report: 02/01/1970
 21. Name of reporter: John Doe
 22. Signature: [Signature]
 23. Title: Officer
 24. Department: Springfield Police Dept
 25. District: 1st
 26. Division: 1st
 27. Subdivision: 1st
 28. Unit: 1st
 29. Shift: 1st
 30. Date of report: 02/01/1970
 31. Time of report: 10:00 AM
 32. Location of report: Springfield, IL
 33. Date of report: 02/01/1970
 34. Time of report: 10:00 AM
 35. Location of report: Springfield, IL

What identification solution was used in exam? _____
 Name of child in this another, including previous birth _____
 FULL NAME _____
 Robert H. Stone _____
 RESIDENCE _____
 Springfield, Illinois _____
 COLOR _____
 White _____
 BRITISH _____
 Occupation _____
 Teacher _____
 AGE AT LAST BIRTHDAY _____
 44 _____

1. NAME
 2. MAIDEN NAME
 3. FULL
 4. ADDRESS
 5. RESIDENCE
 6. COLOR
 7. WHITE
 8. BIRTHPLACE
 9. DATE
 10. OCCUPATION
 11. HOME ADDRESS
 12. TELEPHONE
 13. YACHTING
 14. TRAVELING
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 100. TRAVELING

137

THE PHYSICIAN OF MIDWINTER
 1944
 and, who was / in /
 (1944)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **49870**
Registered No. **67**

1. PLACE OF DEATH **RECEIVED**
Registration District No. **121**
County of **Bingham** **8** **1925**
Primary Registration District No. **2194**
City of **Springfield** **BUREAU OF VITAL STATISTICS** (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **James Stone**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH. **June 8 1925**
(Month) (Day) (Year)

June 8 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many... hrs. or
min. >)

17. I HEREBY CERTIFY, That I attended deceased from **June 8 1925** to **June 8 1925**,
and that death occurred on the date stated above, at **4:30 P.M.**
The CAUSE OF DEATH* was as follows:

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

None

Face presentation for caps delirium
(Duration) **5** yrs. mos. ds.

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robert H. Stone

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

James Gaden

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

P. H. Stone
Springfield, Idaho

(Signed) **W. H. Stone** M. D.
1925 (Address) **Bluff, Idaho**

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days In the State... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Riverview - Thomas **June 8 1925**

UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

799 201 226 864

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of *Bannock*

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

City of *Shelley*

No. _____ St. _____ Registration District No. *121* State File No. *132275*

Hospital _____ Primary Registration District No. *8194* Local Registrar's No. *179*

FULL NAME OF CHILD

Maile V. Priest

(Certificate of no value without full name of child)

Sex of Child *Female* Twin Triplet or other? _____ and { Number in order of birth _____ Legiti- mate? _____ Date of birth *June 1* 192*5*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? *Sal Cap No. 3*

Number of child of this mother, including present birth *12* Number of child of this mother now living, including present birth *10*

FATHER
FULL NAME *Wm E. Priest*
RESIDENCE *Shelley Id*
COLOR *W* AGE AT LAST BIRTHDAY *48* (Years)
BIRTHPLACE *Utah*
OCCUPATION *Farmer*

MOTHER
FULL MAIDEN NAME *Maile Young*
RESIDENCE *Shelley Id*
COLOR *W* AGE AT LAST BIRTHDAY *43* (Years)
BIRTHPLACE *Utah*
OCCUPATION *House wife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *born alive* at *Shelley* on the date above stated. *June 1 1925* A. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *F. D. Roberts*

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed *July 5* 192*5* *Mrs. L. A. Smith*

Registrar.

Registrar.

100

2025 RELEASE UNDER E.O. 14176

RECEIVED
JAN 10 1964

STATE OF NEW YORK

Registration District No. _____ State File No. _____

Primary Registration Number

LEAD MR. MARK JEFFE

to enter the readily enter and to a certain

[illegible]

19970 ni boan anay nabilela labintatod inday

1. Number of children in the household

NAME	FATHER	MOTHER
NAME	FATHER	MOTHER

RECEIVED

AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
1944	1944	1944	1944

BIRTH OF A NATION

100-443886-1000

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

...that I attended the birth of this child, who was (Sullivan) at ...

on the 11th, 1941, at 10:30 a.m.

When I was attending physician
on military then the father had no other.
It shows make this return A different
child in that method provided not
shows other evidence at the same time.

18 Apr 1951

(Collection 10 3015704)

329155A

0914

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
 City of Shelley

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JUL 8 1925

BUREAU OF VITAL STATISTICS

Union District No. 2194
 St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 49878
 Registered No. 9-9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Priest

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH June 1 1923
 (Month) (Day) (Year)

7. AGE Still born IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Bingham Co Idaho

10. NAME OF FATHER

Wm E Priest

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Marle Young

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. E. Priest
Shelley Idaho

15. June 4 1925
 Filed McWalter E. Pature
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1923 to June 1 1924
 that I last saw him born dead and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

born dead

Contributory
 (Secondary)

(Signed)

June 1 1924 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Taylor Cemetery June 1 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
235-218 009-219
County of Bonner
City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JUL 8
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

132332

No. _____ St. _____ Registration District No. 76 State File No. _____
Hospital _____ Primary Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin <u>Twin</u> Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth <u>2</u>	Legitimate? <u>yes</u>	Date of birth <u>June 18</u> <u>1925</u> (Month) (Day) (Year)
--------------------------	--	---	------------------------	--

What bactericidal solution was used in eyes? Silver Nitrate 1%

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 8

FATHER
FULL NAME

Anton Slette

RESIDENCE

Sandpoint

COLOR

White

AGE AT LAST BIRTHDAY 37
(Years)

BIRTHPLACE

Norway

OCCUPATION

Laborer

MOTHER
FULL MAIDEN NAME

Mena Karlstad

RESIDENCE

Sandpoint

COLOR

White

AGE AT LAST BIRTHDAY 34
(Years)

BIRTHPLACE

Norway

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7:25 P.M. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. D. Wallen

M.D.

(Physician or midwife)

Address Sandpoint, Ida

Filed July 6 1925

Viola Allen
Deputy Registrar.

Registrar.

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis**, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
294 184 014 - 315
County of Canyon
City of Wilder

No. _____ St. _____ Registration District No. 3 State File No. 132401
Hospital _____ Primary Registration District No. 2005 Local Registrar's No. 102

FULL NAME OF CHILD Mary

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	} and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>June 4</u> 192 <u>5</u> (Month) (Day) (Year)
--------------------------	---	--	------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1st Number of child of this mother now living, including present birth 1st

FATHER
FULL NAME George Simpson
RESIDENCE Keyburn Ida.
COLOR W. AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Rosette Cannon
RESIDENCE Wilder
COLOR W. AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Parma Ida.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn ^{Deceased} at 1:20 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Robert E. Tallent
W.D.
(Physician or midwife)

Address Wilder Idaho

Filed 6-4-1925 John S. Meyer
Registrar. Registrar.

Dep of 1925-133882

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Canyon*

City of *Childers*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

JUN 12 1925

Registration District No. *3*

BUREAU OF VITAL STATISTICS
Registration District No. *2005*

(No.)

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *49780*

Local Registrar's No. *54*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Single
(Write the word)

6. DATE OF BIRTH

June

4

1925

(Month)

(Day)

(Year)

7. AGE

Shelburne

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Canyon County Idaho

10. NAME OF

Father

Geo Simpson

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Rosetta Corman

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. L. Briggs

(Address)

Childers Idaho

15.

Filed

June 4 - 1925

John H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

4

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Shelburne 19 to 19

that I last saw him alive on *Shelburne* 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Shelburne Corman

not known

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/4 1925 (Address) *Childers Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Roswell Cemetery

DATE OF BURIAL

6-6-1925

20. UNDERTAKER

Parent & Neighbors

ADDRESS

Childers Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

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accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
263-202 014 954
County of Canyon
City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 3 State File No. 132418
Hospital Caldwell Sanitarium Primary Registration District No. 2005 Local Registrar's No. 82

FULL NAME OF CHILD _____

(Cesarean Section)

(Certificate of no value without full name of child)

Sex of Child	<u>Female</u>	Twin Triplet or other?	and {	Number in order of birth	Legitimate?	Date of birth	<u>5/2</u>	<u>1925</u>
		(To be answered only in event of plural births)			<u>Yes</u>	(Month)	(Day)	(Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth ---

FATHER
FULL NAME Talcott L. Bollman

MOTHER
FULL MAIDEN NAME Hazel Redman

RESIDENCE
Notus, Idaho

RESIDENCE
Notus, Idaho

COLOR White AGE AT LAST BIRTHDAY 45
(Years)

COLOR White AGE AT LAST BIRTHDAY 35
(Years)

BIRTHPLACE
Iowa

BIRTHPLACE Iowa

OCCUPATION
Farmer

OCCUPATION
Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 8:30 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) S. B. Dudley

Caldwell, Idaho H. D.
(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed 5-13- 1925

Registrar.

Registrar.

THIS CERTIFICATE IS NOT VALID UNLESS IT IS ACCOMPANIED BY A PHOTOGRAPH OF THE CHILD AND A STATEMENT FROM THE PHYSICIAN OR MIDWIFE ATTENDING THE CHILD THAT THE CHILD IS ALIVE AND WELL.

1922
 Registrar
 I hereby certify that I attended the birth of this child, who was born on the date above stated.
 I have named after him a nomenclature report shows other evidence of his alive birth.
 This is one last mother's breast not one should have been taken. A newborn child should be in his home. I have named after him a nomenclature report.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

NAME FULL NAME FATHER NAME RESIDENCE		NAME FULL NAME MOTHER NAME RESIDENCE	
COLOR AGE AT LAST BIRTHDAY BIRTHPLACE OCCUPATION		COLOR AGE AT LAST BIRTHDAY BIRTHPLACE OCCUPATION	

Number of child of this mother including present birth
 Number of child of this mother including present birth
 Date of birth (month) (day) (year)
 Date of birth (month) (day) (year)
 Sex of child (male or female)
 Sex of child (male or female)

Name of child
 Name of child
 Date of birth (month) (day) (year)
 Date of birth (month) (day) (year)
 Sex of child (male or female)
 Sex of child (male or female)

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Bollman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

White

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

May 3-25

(Month)

(Day)

(Year)

7. AGE

Stillborn

Yrs.

Mos.

ds.

IF LESS than 1
day how many

hrs. or

min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

T. L. Bollman

11. BIRTHPLACE

OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME

OF MOTHER

Hazel Redman

13. BIRTHPLACE

OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filled

May - 4 -

1925

John S. Meyers
Local Registrar

RECEIVED
MAY 14 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Registration District No. 2005

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

49502

Local Registrar's No.

44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 3-25

(Month)

(Day)

19 25

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 3 1925 to May 3 1925

that I last saw him alive on Stillborn May 3 1925

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Still born - Complication of parturition

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

19 (Address)

St. Dudley M. D.
Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....days. State.....yrs.....mos.....ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

May 4-2519

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

285 225 014 279

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Caldwell
City of Caldwell
No. Caldwell Sanitarium St.

Registration District No. 3

File No. 132423

Hospital

Primary Registration District No. 2005

Registered No. 98

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	<u>Twins</u> Triplet or other? (To be answered only in event of plural births)	and { <u>Number</u> in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>5/25</u> (Month) (Day) (Year) <u>1925</u>
----------------------------	--	---	------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 4..... Number of child of this mother now living, including present birth 3.....

FATHER
FULL NAME Roy Harrison Shelp

RESIDENCE
R. # 2, Caldwell, Idaho

COLOR White AGE AT LAST BIRTHDAY 36
(Years)

BIRTHPLACE
Neb.

OCCUPATION

Farming

MOTHER
FULL MAIDEN NAME Nettie Clara Sprang

RESIDENCE
R. # 2, Caldwell, Idaho

COLOR White AGE AT LAST BIRTHDAY 30
(Years)

BIRTHPLACE
Colo

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was stillborn at 8 A M.
on the date above stated. (Born alive or stillborn)

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature) E. M. Kaley

M. D.

(Physician or midwife)

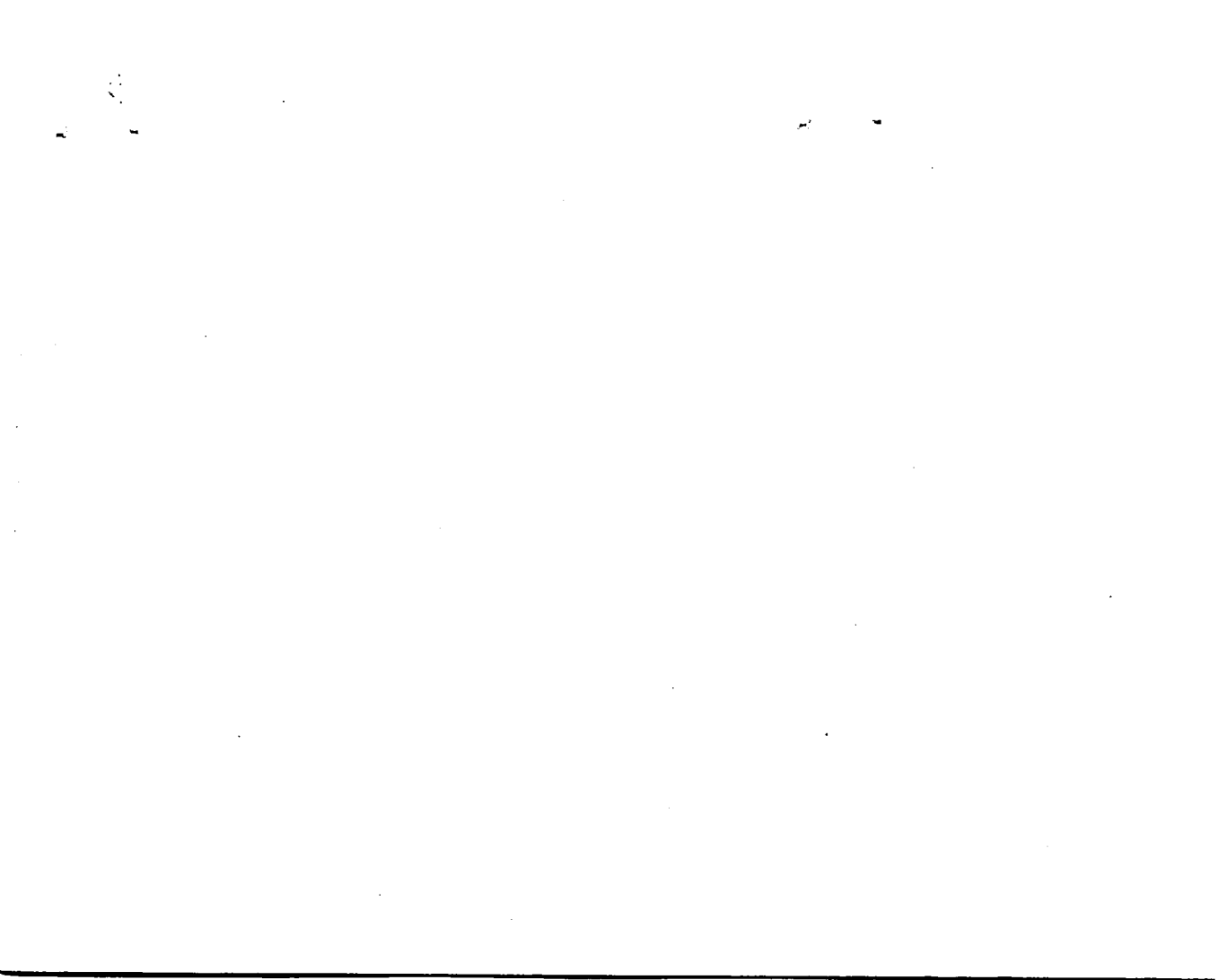
Give names added from a supplemental report.

Address Caldwell, Idaho

Filed 5-25-1925

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Shelp

(No.)

(St.)

State File No.

49783

Local Registrar's No.

57-

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED

girl

white

(Write the word)

5. DATE OF BIRTH

May

25-

1925

(Month)

(Day)

(Year)

6. AGE

IF LESS than 1 day how many hrs. or min.?

Yrs. Mos. ds.

7. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

8. BIRTHPLACE

(State or Country)

Idaho

9. NAME OF FATHER

Father

Roy Shelp

10. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

11. MAIDEN NAME OF MOTHER

(State or Country)

Nettie C. Sprang

12. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy Shelp

(Address)

Caldwell Ida RR#2

15. Filled

May 26 1925

J. H. Shelp
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

25

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1925 to May 25 1925

that I last saw deceased rather close and that death occurred on the date stated above, at N.

The CAUSE OF DEATH* was as follows:

still born
leg to be detached
preceded

(Duration)

Contributory (Secondary)

(Duration)

(Signed)

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

May 26 1925

20. UNDERTAKER

C. V. Peckham

ADDRESS

Caldwell, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

293104 020-537

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

S

County of Elmore

JUL 3 1925

CERTIFICATE OF BIRTH

City of Mtn. Home

BUREAU OF VITAL
STATISTICS

Registration District No. 34

File No. 132525

No. _____ St.

Primary Registration District No. 2020

Registered No. 18

Hospital _____

FULL NAME OF CHILD _____

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimacy? <u>Yes</u>	Date of Birth <u>June 4</u> 19 <u>25</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

FATHER
FULL NAME William Bilbao
RESIDENCE Mtn. Home Ida.
COLOR White AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Spain
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Engracia Elquezabal
RESIDENCE Mtn. Home Ida.
COLOR White AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Spain
OCCUPATION _____

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 7:10 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. E. Evans

(Physician or midwife)

Given names added from a supplemental report.

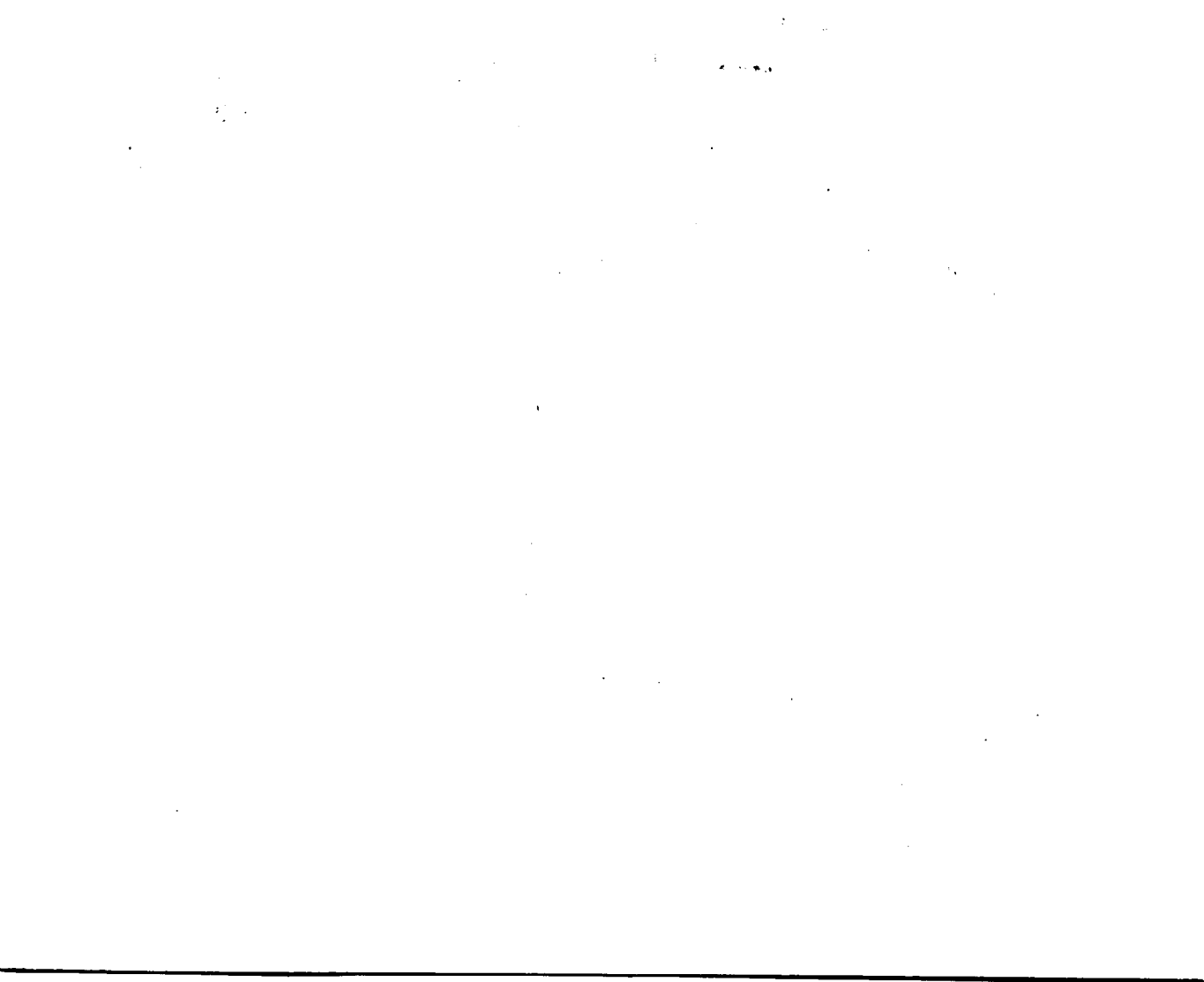
19

Address Mtn. Home, Ida.

Filed June 20 1925

Registrar

Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

319 102 020 -291
PLACE OF BIRTH

RECEIVED

JUL 7 1925

BUREAU OF VITAL

STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Elmore

City of Elmer's Ferry

No. _____ St. _____

Hospital _____

Registration District No. 2021

File No. 132528

Registered No. _____

FULL NAME OF CHILD unnamed

(Certificate of no value without full name of child.)

Sex of
Child

Male

Twin
Triplet
or other?

{ and {

Number
in order
of birth

3

Legiti-
mate?

yes

Date of
birth

April 2nd

1925

(Month)

(Day)

(Year)

What bacterioidal solution was used in eyes? None

Number of child of this mother, including present birth... 3

Number of children of this mother now living, including present birth... 1

FULL
NAME

FATHER

Walter Cazier

RESIDENCE

Elmer's Ferry Idaho

COLOR

White

AGE AT LAST

BIRTHDAY 25
(Years)

BIRTHPLACE

Montana

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Mellie Lucille Branan

RESIDENCE

Elmer's Ferry Idaho

COLOR

White

AGE AT LAST

BIRTHDAY 25
(Years)

BIRTHPLACE

Illinois

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

April 2nd 1925 at 11:40

(Respective or stillborn)

P

M.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. W. Davis

Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Elmer's Ferry Idaho

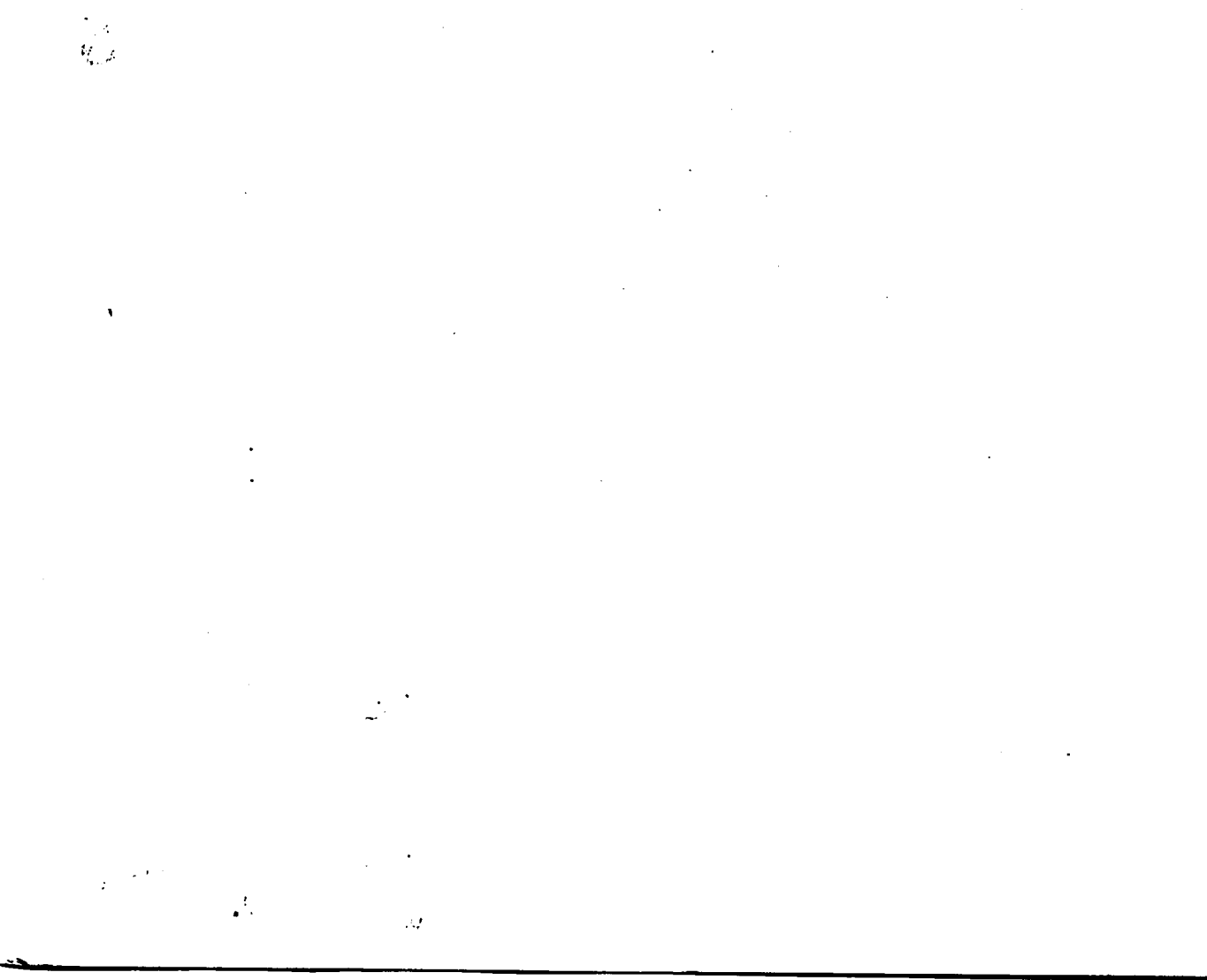
Filed

April 3rd 1925

J. W. Davis

Registrar.

Registrar.



PLACE OF BIRTH

RECEIVED

JUL 7 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of *Glenway*City of *Glenway*BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. *753-228020-418*Registration District No. *35*File No. *132532*

Hospital

Primary Registration District No. *2021*

Registered No.

FULL NAME OF CHILD

Deceased

(Certificate of no value without full name of child.)

Sex of Child

*Male*Twin
Triplet
or other?*✓*

and

Number
in order
of birth*✓*Legiti-
mate?*Yes*Date of
birth*Jan 28 1925*

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? *✓*Number of child of this mother, including present birth *1*Number of children of this mother now living, including present birth *0*FULL
NAME*Wm. E. Peterson*

FATHER

FULL
MAIDEN
NAME*Hettie Dayley*

MOTHER

RESIDENCE

Glenway

RESIDENCE

Glenway

COLOR

*white*AGE AT LAST
BIRTHDAY*43*
(Years)

COLOR

*white*AGE AT LAST
BIRTHDAY*23*
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

Hostler

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.*still born - 8:05 A.M.*
(Born alive or stillborn)*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

G. W. Jones M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Glenway Idaho

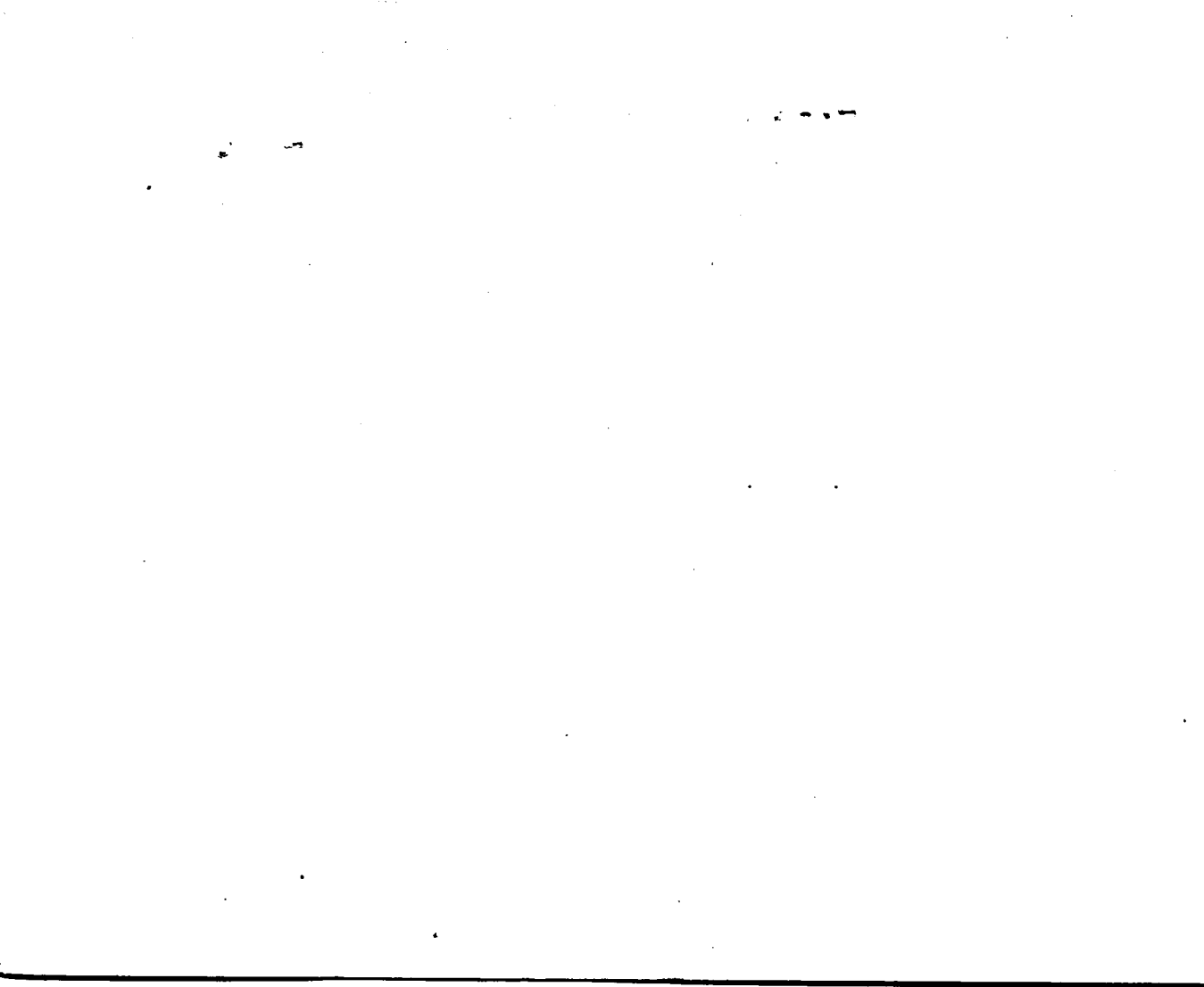
Filed

*June - 10 - 1925**J. W. Jones*

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Elmore
City of Elmer's Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Peterson

RECEIVED
CERTIFICATE OF DEATH
MAR 9 1925
Registration District No. 35
BUREAU OF VITAL STATISTICS
Registration District No. 2021
(No.) St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 18757

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word)

6. DATE OF BIRTH

Jan 28 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds. 0

IF LESS than 1 day, how many hrs. or min.?
0 hrs. 0 min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

W. E. Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Hettie Hayley

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William E. Peterson

(Address)

Elmer's Ferry Idaho

15.

Filed

Jan. 281925J. W. Davis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

189-6

16. DATE OF DEATH

Jan 28 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1925 to Jan 28 1925

~~that I last saw him alive on~~ Jan 28 1925
~~and that death occurred on the date stated above, at~~ 8 H M.

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) yrs. mos. ds.

Contributory (Secondary)

Prematurity

(Duration) yrs. mos. ds.

(Signed)

1/28/1925 (Address) Elmer's Ferry Idaho

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elmer's Ferry IdahoJan. 29 1925

20. UNDERTAKER

ADDRESS

William E. Peterson Elmer's Ferry Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED

JUL 17 1925

CERTIFICATE OF BIRTH

S

County of ClatsopCity of HammettNo. 653-109020-279 St.

BUREAU OF VITAL STATISTICS

Registration District No. 35File No. 132549

Hospital

Primary Registration District No. 2021

Registered No.

FULL NAME OF CHILD

unnamed

(Certificate of no value without full name of child.)

Sex of Child

MaleTwin
Triplet
or other?

- {

and {

Number
in order
of birth1Legiti-
mate?noDate of
birthApril 91925

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? noneNumber of child of this mother, including present birth... 1Number of children of this mother now living, including present birth... 0FULL
NAMEFATHER
Laurie WellsFULL
MAIDEN
NAMEMOTHER
Hattie Kuh

RESIDENCE

Mountain Home Idaho

RESIDENCE

Hammett Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY21

(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY19

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

stockman

OCCUPATION

Housework

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

April 9, 1925, at 2:30P M.

on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. W. DavisGlenn's Ferry Idaho

(Physician or midwife)

Give names added from a supplemental report.

Address

Glenn's Ferry Idaho

Filed

April 11, 1925J. W. Davis

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

STATE
DEPARTMENT OF
REVENUE



Form with multiple horizontal lines for text entry. The form is mostly blank, with some faint, illegible markings and a large diagonal line drawn across the right side.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of *Elmore*

City of *Hammett*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

BUREAU OF VITAL STATISTICS

STATISTICS

District No.

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *white* *Single*
(Write the word)

6. DATE OF BIRTH

April *9th* *1925*
(Month) (Day) (Year)

7. AGE

still Born

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Laurin Wells

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Hattie Kuhl

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hattie Kuhl

(Address)

Hammett Idaho

15.

Filed

April 11 *1925* *J. W. Davis*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April *9th* *1925*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 8th* *1925* to *April 9th* *1925*, that I last saw *him* alive on *April 8th* *1925*, and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

Delayed labor

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Davis

M. D.

4-11-1925 (Address) *Hammett Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Hammett Idaho

DATE OF BURIAL

April 10 1925

20. UNDERTAKER

Mr Kuhl

ADDRESS

Hammett Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

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238 227 024 314
PLACE OF BIRTH

RECEIVED

JUL 8 1925

Form V. S. No. 11-C--25m-7-21-19

BUREAU OF VITAL
STATISTICS

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of GoodingCity of HagermanRegistration District No. 21File No. 132659

No. _____ St. _____

Primary Registration District No. ✓

Registered No. _____

Hospital _____

FULL NAME OF CHILD

Norma SchooleSex of Child Female Twin Triplet or other? (To be answered only in event of plural births) and Number in order of birth 2 Legiti mate? YesDate of Birth June 27 1925
(Month) (Day) (Year)FULL NAME FATHER E. W. SchooleFULL MAIDEN NAME MOTHER Rosa CampbellRESIDENCE HagermanRESIDENCE HagermanCOLOR White AGE AT LAST BIRTHDAY 47 (Years)COLOR White AGE AT LAST BIRTHDAY 44 (Years)BIRTHPLACE IdahoBIRTHPLACE ColoOCCUPATION FarmerOCCUPATION HousewifeNumber of child of this mother, including present birth 13 Number of children of this mother now living, including present birth 13

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still Born at 10 30 a M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. H. Greene(Physician or midwife) Physician

Given names added from a supplemental report.

19

Address HagermanFiled July 1 1925R. H. Greene
RegistrarThis child had perhaps been dead 2 months - encephalus

THE UNIVERSITY OF CHICAGO PRESS

100

72

50129

ॐ

old friend of the author

起

Primary Election District No.

[illegible]

5. Indicate
refuse at him
should be
Indicate to move at the

RECEIVED

102-103

1998

1. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

2. Explain the importance of the following:

TRAJ TO RM

6229Y1

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1. STATE OF TEXAS

2. COUNTY OF DALLAS

3. BEFORE ME, the undersigned authority, on this day personally appeared

4. JOHN A. SMITH, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

5. GIVEN UNDER MY HAND AND SEAL OF OFFICE this 15th day of January, 2024.

6. _____

7. Notary Public in and for the State of Texas

8. My Commission Expires: 12/31/2025

9. JOHN A. SMITH

10. Witness my hand and seal of office this 15th day of January, 2024.

11. _____

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116. _____

117. Notary Public in and for the State of Texas

118. My Commission Expires: 12/31/2025

119. JOHN A. SMITH

120. Witness my hand and seal of office this 15th day of January, 2024.

121. _____

122. Notary Public in and for the State of Texas

123. My Commission Expires: 12/31/2025

124. JOHN A. SMITH

125. Witness my hand and seal of office this 15th day of January, 2024.

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127. Notary Public in and for the State of Texas

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138. My Commission Expires: 12/31/2025

139. JOHN A. SMITH

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142. Notary Public in and for the State of Texas

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162. Notary Public in and for the State of Texas

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164. JOHN A. SMITH

165. Witness my hand and seal of office this 15th day of January, 2024.

166. _____

167. Notary Public in and for the State of Texas

168. My Commission Expires: 12/31/2025

169. JOHN A. SMITH

170. Witness my hand and seal of office this 15th day of January, 2024.

171. _____

172.

...and now this night in which we have been so long...

12001312

12. Substantive matters on June 1967 -
13. Substantive matters on June 1967 -
14. Substantive matters on June 1967 -
15. Substantive matters on June 1967 -

SECRET

•

improvement

Index

RECEIVED

JUL 8 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Gooding*
City of *Hagerman*Registration No. *21*
Location District No. _____
St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Norma Schooler*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *49952*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Infant

6. DATE OF BIRTH

June 27 1925
(Month) (Day) (Year)

7. AGE

Still Born
IF LESS than 1 day
how many _____ hrs.
Yrs. _____ Mos. _____ ds. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. H. Schooler

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Rosa Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. H. Schooler
Hagerman

(Address)

15.

Filed

July 1 1925
R. H. Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

189-b

16. DATE OF DEATH

Had been dead
for perhaps 2 m.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____

that I last saw him _____ alive on _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. H. Greene M. D.19. (Address) *Hagerman*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerman *June 7 1925*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

751 016 027 249

County of Jerome

City of Jerome

No. _____ St. _____

Hospital Home

FULL NAME OF CHILD _____

RECEIVED

JUL 11 1925

BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS

Registration District No. 93

Primary Registration District No. 1017

Stillborn 2017

(Certificate of no value without full name of child.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

File No. 132707

Registered No. _____

Sex of
Child

Twin
Triplet
or other?

and

Number
in order
of birth

1

Legiti-
mate?

yes

Date of
birth

May 16 1925

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Stillborn 1309 M.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

C. T. Zeller

(Physician or midwife)

Give names added from a supplemental report.

Address

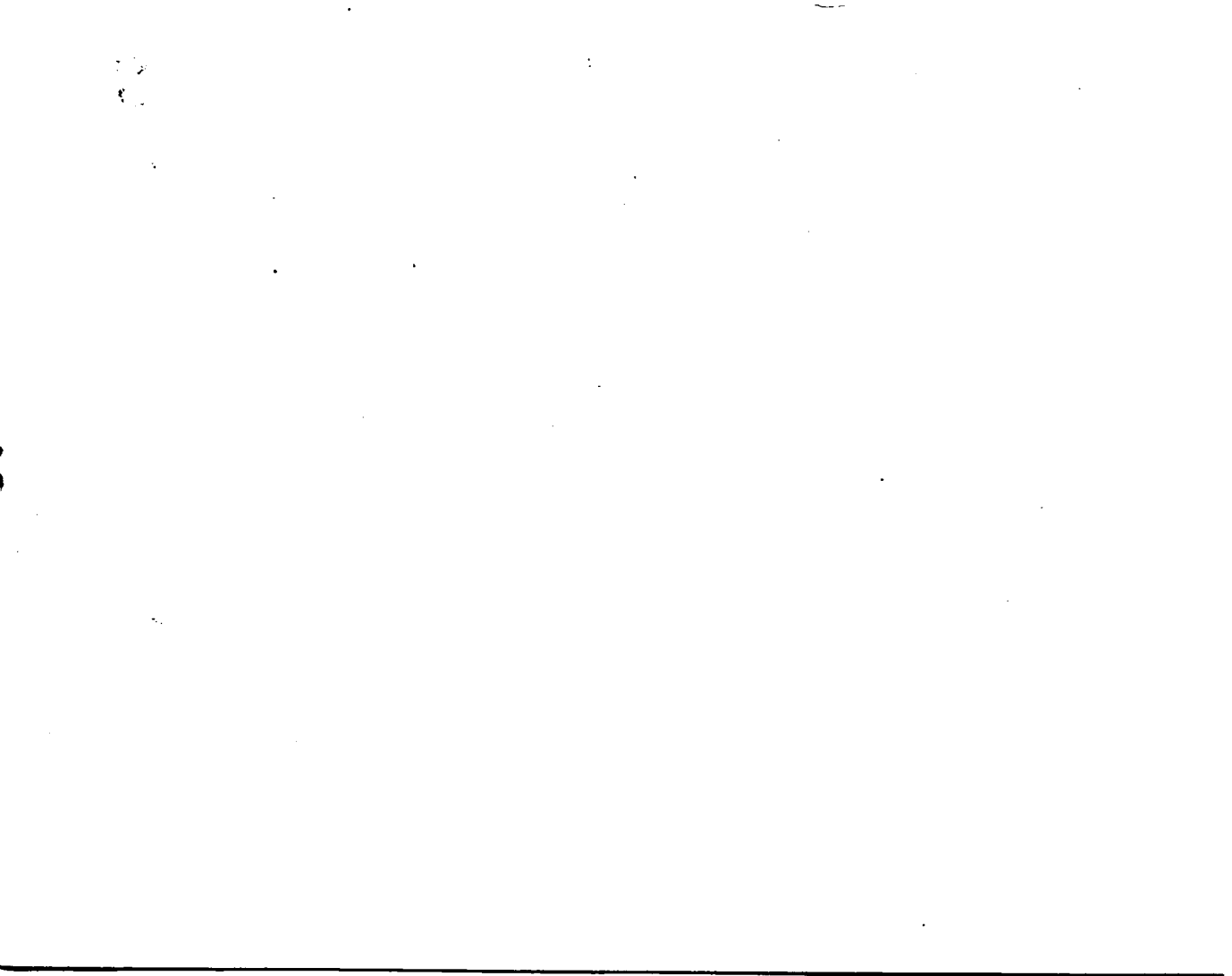
Jerome, Ida.

Filed

July 3 1925

Registrar.

Registrar.



PLACE OF BIRTH

RECEIVED
JUL 6 1925
BUREAU OF VITAL STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

132799

Sx

County of KootenaiCity of Black Lake

CERTIFICATE OF BIRTH

No. 662129 028 234St. Registration District No. 126State File No. 8Hospital StillbirthPrimary Registration District No. 2304Local Registrar's No. 8FULL NAME OF CHILD Stillbirth

(Certificate of no value without full name of child)

Sex of Child MTwin
Triplet
or other?and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate? yesDate of birth May 291925

(Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓Number of child of this mother, including present birth 2Number of child of this mother now living, including present birth 1FULL
NAME

FATHER

Albert L. Fosket

RESIDENCE

Black Lake Ida

COLOR

White

AGE AT LAST

BIRTHDAY 37

(Years)

BIRTHPLACE

Missouri

OCCUPATION

LaborerFULL
MAIDEN
NAME

MOTHER

Isabel Scully

RESIDENCE

Black Lake Ida

COLOR

White

AGE AT LAST

BIRTHDAY 30

(Years)

BIRTHPLACE

Ill.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 5:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Narl J. May
Physician
(Physician or midwife)

Address

Harrison Ida

Filed

July 1 1925N. J. May

Registrar

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
155 E. 42ND STREET
NEW YORK 17, N. Y.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Miner **RECEIVED**
 City of Rupert **JUL 8 1925** **CERTIFICATE OF BIRTH**
 No. 343112034367 **BUREAU OF VITAL STATISTICS** District No. 19 State File No. 132929
 Hospital _____ Primary Registration District No. 2015 Local Registrar's No. 56
FULL NAME OF CHILD Unnamed Culley
 (Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? _____ } and { Number in order of birth _____ Legiti- mate? yes Date of birth June 12 1925
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Mer. salub.

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER

FULL NAME Cloyd Joel Culley
RESIDENCE Rupert, Idaho
COLOR white **AGE AT LAST BIRTHDAY** 28
 (Years)
BIRTHPLACE Illinois

MOTHER

FULL MAIDEN NAME Florence Alta Cox
RESIDENCE Rupert, Idaho
COLOR white **AGE AT LAST BIRTHDAY** 22
 (Years)
BIRTHPLACE Oregon

OCCUPATION Camp man, Irrigation District**OCCUPATION** Idaho**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE**

I hereby certify that I attended the birth of this child, who was { Stillborn } at 4:50 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Leland Hagin, M.D.

(Physician or midwife)

Address Rupert, IdahoFiled 7-4 1925 Elmore

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

Handwritten text on a piece of paper, likely a letter or document, with some words appearing to be in a different script or language. The text is mostly illegible due to the image quality and orientation.

DATE OF ATTENDING PHYSICIAN OR MIDWIFE

(attaches to dispatch)

(S) (C)

I would certify that I attended the birth of this child, who was [redacted] at [redacted]

CONFIDENTIAL

503-1741-1100

TRAJ TA 304
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NO. 307

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2000年12月

AMERICAN
UNIVERSITY
LIBRARY

RENTON

Number of child of this mother, including present birth

Number of side of this machine and driver. In order to account for

fact: we have now collected information indicating

It is answered only in terms of blood.

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bilit

100-443887-100

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Feb 21
1954

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10-10-68

(Certificate of the value without the value of the)

U.S. DEPT. OF JUSTICE

1951年12月29日

REPORT

1938

1948

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Minnesota
City of P.O. Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

RECEIVED

Registration District No. 19

Primary Registration District No. 2015

BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 50035

Local Registrar's No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

June 12 1925
(Month) (Day) (Year)

7. AGE

Stillborn Infant
Yrs. Mos. ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country) Minnesota

10. NAME OF FATHER

Cloyd J. Culley

11. BIRTHPLACE OF FATHER

(State or Country) Illinois

12. MAIDEN NAME OF MOTHER

Florence E. Cox

13. BIRTHPLACE OF MOTHER

(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Cloyd J. Culley
Rupert, Idaho

15.

Filed June 13 1925 E. E. Moore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 12 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Stillborn 19 to June 12 1925

that I last saw him alive on Stillborn 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn Infant

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leland Frazier M. D.

19 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

995-125-038-133

PLACE OF BIRTH

County of

Nez Perce

City of

Lapwai

No.

St.

Hospital

Primary Registration District No.

Registered No.

FULL NAME OF CHILD

Un named

Sex of Child

Male

Twin
Triplet
or other?

and } Number
in order
of, birth

(To be answered only in event of plural births)

Legiti
mate?

Yes

Date of Birth

May 25 1925

(Month) (Day) (Year)

FULL NAME

Watkins Ezekiel

FATHER

FULL MAIDEN NAME

Mary Allen

MOTHER

RESIDENCE

Lapwai Idaho

RESIDENCE

Lapwai Idaho

COLOR

Indian 1/4

AGE AT LAST BIRTHDAY

46

(Years)

COLOR

Indian 1/4

AGE AT LAST BIRTHDAY

21

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Hot Springs Washington

OCCUPATION

Farmer

OCCUPATION

House wife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Still Born

1300

M.

on the date above stated.

(Born alive or stillborn)

1300

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Geo O Keen M. D.
Physician Lapwai Idaho

(Physician or midwife)

Given names added from a supplemental report.

19.

Address

Registrar

Filed

19

May 25 George Guernsey

Registrar

Form V. S. No. 11-C-25m-7-21-19

RECEIVED

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

JUL 11 1925

CERTIFICATE OF BIRTH

BUREAU OF VITAL

STATISTICS

Registration District No.

138

S

File No.

132940

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WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

619 125035-296
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nez Perce
City of Shelbourn Idaho

JUL 11 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 128 State File No. 132948

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? yes Date of birth 6 25 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Pick Ward
RESIDENCE Shelbourn, Idaho
COLOR White AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Idaho
OCCUPATION Common Laborer

MOTHER
FULL MAIDEN NAME Lilly Broncheau
RESIDENCE Shelbourn, Idaho
COLOR 1/2 Indian AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) George Gaignard M.D.

(Physician or midwife)

Address Caldwells Idaho

Filed June 1925 George Gaignard M.D.

Registrar.

Registrar.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____
 Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

(Certificate of no name without full name of child)
 Date of birth _____
 (Month) (Day) (Year)
 Sex _____
 (To be answered only in case of plural births)
 and { }
 of birth { }
 in order { }
 of birth { }

How immediate relation was used to verify?

Number of child of this mother now living including present birth _____
 Number of child of this mother, including present birth _____

FATHER
 FULL NAME
 MOTHER
 FULL NAME
 RESIDENCE _____

AGE AT BIRTH _____
 (Years)
 AGE AT LAST BIRTHDAY _____
 (Years)
 COLOR _____

BIRTHPLACE _____
 OCCUPATION _____
 BIRTHPLACE _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

(Signature) _____
 (Physician or midwife)
 Address _____
 Phone _____

There were no attending physician or midwife present at the birth of this child. A witness who would make this return is one that neither parent nor any other member of the same birth.

For names added from a supplemental report
 195 _____

NEW YORK STATE DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 125 NASSAU ST. NEW YORK 10038

1. PLACE OF DEATH

County of *Perce*City of *Blackfoot Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATH
 JUL 1 1925
 Registration District No. *128*
 Bureau of Vital Statistics
 State of Idaho
 File No. *50043*
 Registered No. _____

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *50043*
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male Indian 1/4

(Write the word.)

6. DATE OF BIRTH

6 25 1925
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Pick Ward*(Address) *Blackfoot Idaho*

15.

Filed *June 19 25**19 25**George Gagnier*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 25 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19, to _____ 19

that I last saw h. alive on _____ 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *George Gagnier*

June 19 25 M. D.

(Address) *Blackfoot Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Ida. 6-26-1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

369 114 035-618

PLACE OF BIRTH

RECEIVED

JUL 6 1925

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of *My Per*

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

S 132951

City of *Gifford*

Registration District No. *92*

File No. *70*

No. _____ St.

Primary Registration District No. *2170*

Registered No. *21*

Hospital _____

FULL NAME OF CHILD *Baby Correll*

Sex of Child <i>M</i>	Twin Triplet or other? _____ } and { Number in order of birth (To be answered only in event of plural births)	Legiti mate? <i>yes</i>	Date of Birth <i>6 14 1925</i> (Month) (Day) (Year)
-----------------------	--	----------------------------	---

FULL NAME <i>B. Gay Correll</i>	FATHER
RESIDENCE <i>Gifford</i>	
COLOR <i>M</i>	AGE AT LAST BIRTHDAY <i>31</i> (Years)
BIRTHPLACE <i>Wash</i>	
OCCUPATION <i>farmer</i>	

FULL MAIDEN NAME <i>Ethel Wahl</i>	MOTHER
RESIDENCE <i>Gifford</i>	
COLOR <i>M</i>	AGE AT LAST BIRTHDAY <i>33</i> (Years)
BIRTHPLACE <i>Idaho</i>	
OCCUPATION <i>house</i>	

Number of child of this mother, including present birth *2* Number of children of this mother now living, including present birth *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *still born*, at *8 2* M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) *E. E. Watts*

(Physician or midwife)

Given names added from a supplemental report.

19

Address _____

Filed *6-14 1925* *E. E. Watts*

Registrar

Registrar

BTBIB

Registration District No.

招

Primarily Registration District No. _____ Registered No. _____

FULL NAME OF CHILD

30 2048
b1d53

(To be answered only in event of change of address)

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PRELIMINARY

RIGHT

NAME
MAIDEN
FULL

MOTHER

RESEARCH

REB103182A

COLORED

AGE AT LAST
BIRTHDAY

BIRTHDAY...
AGE AT LAST

DOCUMENT

BIRTHPLACE

OCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

(Return this to your agent)

(ozustanjiš)

(Physician or midwife)

... (faint text) ...

207bba

41-0449

Dr. J. H. H. H.

[illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

50036

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED**
County of **Bluff** Registration District No. **92**
City of **Bluff** Primary Registration District No. **2170**
St. **Idaho**

File No. **7**
Registered No. **33**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Cornell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH.

6 **14** **1925**
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. G. Cornell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ethel Wahl

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

H. G. Cornell

(Address)

Bluff Idaho

15.

Filed

6 - 14

1925

E. E. Gratt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 **14** **1925**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

still born
Premature

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. E. Gratt

M. D.

6-14-1925 (Address)

Bluff

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bluff Idaho

DATE OF BURIAL

6-16-1925

20. UNDERTAKER

H. E. Stoddard

ADDRESS

Sewiston

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of *Key Pierce*RECEIVED
JUL 11 1925City of *Caldwell*

BUREAU OF VITAL CERTIFICATE OF BIRTH

No. *944-219035755*

St.

STATISTICS

Registration District No. *128*

State File No.

132960

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

Eveling Ruddle

(Certificate of no value without full name of child)

Sex of Child

*Female*Twin
Triplet
or other?

}

and { Number
in order
of birth*2*Legiti-
mate?*yes*Date of
birth*3**19**1925*

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *2*Number of child of this mother now living, including present birth *none*FULL
NAME

- FATHER

Clare Ruddle

RESIDENCE

Caldwell Idaho

COLOR

*White*AGE AT LAST
BIRTHDAY*30*

(Years)

BIRTHPLACE

Idaho

OCCUPATION

*Common Laborer*FULL
MAIDEN
NAME

MOTHER

Gladys Jenkins

RESIDENCE

Caldwell Idaho

COLOR

*White*AGE AT LAST
BIRTHDAY*25*

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *born alive* Stillborn { at *10:10* *A.* M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

George J. Jarmund

(Physician or midwife)

Address

Caldwell Idaho

Filed

March 1925

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

2

RECEIVED
JAN 1 1934

County of _____
City of _____
State of _____
Hospital _____
Primary Health Officer District No. _____
Name of Child _____
(Certificate of no value without full name of child)
Date of Birth _____
Sex _____
Race _____
Religion _____
Place of Birth _____
Date of Admission _____
Name of Physician _____
Address _____

Number of child of this mother now living, including any in this _____
MOTHER
Full Name _____
Residence _____
Color _____
Age at Last Birthday _____
Birthplace _____
FATHER
Full Name _____
Residence _____
Color _____
Age at Last Birthday _____
Birthplace _____
Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was _____ at _____
_____ (Physician or Midwife)
Address _____
Signed _____
Date _____

1. PLACE OF DEATH

County of Nez Perce
 City of Caldwell Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
 JUL 11 1925
 BUREAU OF VITAL STATISTICS
 REGISTRATION District No. 128
 Primary Registration District No. _____

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 50044

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____

(Write the word.)

6. DATE OF BIRTH

March 19 1925
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many _____ hrs.
 or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Claire Ruddle

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Gladys Jenkins

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claire Ruddle(Address) Caldwell Ida.

15.

Filled March 25 1925 George Guignard
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 19 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____

_____ 19 _____, to _____ 19 _____

that I last saw him alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn. Premature birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) George Guignard

M. D.

March 25 Address Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldwell Ida. Mar. 19, 1925

20. UNDERTAKER

ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of *Nehalem*City of *Caldwell Idaho*No. *944 2A 035 155*

St.

Regist.

No.

128

State

File

No.

132961

CERTIFICATE OF BIRTH

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

Ethelina Ruddle

(Certificate of no value without full name of child)

Sex of Child

*Female*Twin
Triplet
or other?

} and {

Number
in order
of birth*1*

(To be answered only in event of plural births)

Legitimate?

yes

Date of birth

*3**19**1925*

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth. *2*Number of child of this mother now living, including present birth *none*FULL
NAME

FATHER

Clair Ruddle

RESIDENCE

Caldwell Idaho

COLOR

*White*AGE AT LAST
BIRTHDAY*30*

(Years)

BIRTHPLACE

Idaho

OCCUPATION

*Common Laborer*FULL
MAIDEN
NAME

MOTHER

Gladys Jenkins

RESIDENCE

Caldwell Idaho

COLOR

*White*AGE AT LAST
BIRTHDAY*25*

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *born alive* at *10:00* *A. M.* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

George Guinnard M.D.

(Physician or midwife)

Address

Caldwell Idaho

Filed

March 1925

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

1. Name of child
 2. Date of birth
 3. Place of birth
 4. Sex
 5. Race
 6. Color
 7. Religion
 8. Education
 9. Occupation
 10. Residence
 11. Address
 12. Age at last birthday
 13. Age at birth
 14. Date of last birthday
 15. Date of birth
 16. Date of last birthday
 17. Date of birth
 18. Date of last birthday
 19. Date of birth
 20. Date of last birthday

1. Name of child
 2. Date of birth
 3. Place of birth
 4. Sex
 5. Race
 6. Color
 7. Religion
 8. Education
 9. Occupation
 10. Residence
 11. Address
 12. Age at last birthday
 13. Age at birth
 14. Date of last birthday
 15. Date of birth
 16. Date of last birthday
 17. Date of birth
 18. Date of last birthday
 19. Date of birth
 20. Date of last birthday

RECEIVED

JUL 11 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Key Pierce*
City of *Culdesse Ida.*Registration District No. *128*
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Ethelina Ruddle
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *50045*
Registered No.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

March 19 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Claire Ruddle

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho.*

12. MAIDEN NAME OF MOTHER

Gladys Jenkins

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Claire Ruddle*(Address) *Culdesse Ida.*

15.

Filed *March 25 1925* *George Guernard*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 19 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH was as follows:

Stillborn Premature birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *George Guernard*

M. D.

March 25 1925 (Address) *Culdesse Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Culdesse Ida. March 25 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

JUL 11 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of *My Perce*

City of *Culdesa*

No. *968 207035-257*

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

St. Registration District No. *128*

State File No. *132969*

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD

Stillborn

(Certificate ☒ no value without full name of child)

Sex of
Child

female

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

1 7

(Month) (Day)

1925
(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *none*

Number of child of this mother now living, including present birth *none*

FULL
NAME

FATHER

Carl Rohrman

RESIDENCE

Culdesa Idaho.

COLOR

White

AGE AT LAST
BIRTHDAY

22
(Years)

BIRTHPLACE

Oregon

OCCUPATION

farmer

FULL
MAIDEN
NAME

MOTHER

Hazel Keith

RESIDENCE

Culdesa Idaho.

COLOR

White

AGE AT LAST
BIRTHDAY

20
(Years)

BIRTHPLACE

Iowa

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Born alive* { Stillborn } at *4:00* *1* P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

George Gaignard M.D.

(Physician or midwife)

Address

Culdesa Idaho

Filed

Jan 1925

Registrar.

Registrar.

CERTIFICATE OF BIRTH

Registration Number: _____
 Primary Registration Number: _____

Certificate No. _____

Place of Birth: _____
 Date of Birth: _____
 Time of Birth: _____
 Sex: _____

Signature of Registrar: _____

Signature of Mother: _____

MOTHER

FATHER
 NAME

FATHER

RESIDENCE

RESIDENCE

AGE AT LAST
 BIRTHDAY

COLOR

AGE AT LAST
 BIRTHDAY

COLOR

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was _____ at _____

I further certify that I attended the birth of this child, who was _____ at _____

Physician of this State

Address

City

State

1. PLACE OF DEATH

County of *Ref. Pierce*City of *Culdesa Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *128*

Primary Registration District No.

BUREAU OF VITAL STATISTICS

(No.) (St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *50046*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan

(Month)

7

(Day)

1925

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Carl Rohman

11. BIRTHPLACE OF FATHER

(State or Country) *Oregon*

12. MAIDEN NAME OF MOTHER

Hazel Keith

13. BIRTHPLACE OF MOTHER

(State or Country) *Iowa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. W. Keith*(Address) *Culdesa Idaho*

15.

Filed *Jan**1925**George Gagnard*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896-

16. DATE OF DEATH

Jan

(Month)

7

(Day)

1925

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Stillborn. Eclampsia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *George Gagnard**Jan 1925*Address *Culdesa Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Culdesa Id.**Jan 1, 1925*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Oneida

City of Malden, Idaho

No. 315-20036-853

St. Registration No. 26

State File No. 132981

Hospital

Primary Registration District No. 2069 Local Registrar's No. 96

FULL NAME OF CHILD

Premature

(Certificate of no value without full name of child)

Sex of Child Female

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate?

Date of
birth

6-20 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Argyrol 10%

Number of child of this mother, including present birth

7 Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Walter Thomas Cannon

RESIDENCE

Malden, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

40
(Years)

BIRTHPLACE

Indianapolis, Indiana

OCCUPATION

Produce Dealer

FULL
MAIDEN
NAME

MOTHER

Ruth Nelson

RESIDENCE

Malden, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

30
(Years)

BIRTHPLACE

Summerville, Mo.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Stillborn

Signature 6.7.20.
at 4:45 A.M.

on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

Physician

(Physician or midwife)

Address

Malden, Idaho

Filed

6/30

1925

J. M. Thrus

Registrar.

REMITTANCE OF ATTENDING PHYSICIAN OR MIDWIFE.

is [redacted] saw [redacted] with [redacted] at [redacted] [redacted]

1. The first of these is the fact that the
2. Government has not been able to secure
3. the necessary funds to carry out its
4. policy of non-interference in the
5. internal affairs of the country.

SECRET

240166

1947

COGNITION

32. J. 11. 11. 11.

90501

TABLE 2
CENTRIS

SECRET

1-117
HACIA
BACIA

MOTHER

RIGHTS

234

...of the world of the ... including present ...

They have been our greatest laboratory and

It is requested that you advise the Bureau of the results of your investigation.

-11-
12100

10 6100

(vs1) (dlg03)

...and the ...

USING - 111

4 130000 1000000 1000000

0484398

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Quincy

City of Malad

No. 165 207036415

St. Registration District No. 26

State File No. 132988

Hospital

Primary Registration District No. 2069

Local Registrar's No. 89

FULL NAME OF CHILD

Marguerite Jones

(Certificate of no value without full name of child)

Sex of
Child

Female

Twin
Triplet
or other?

}

and {

Number
in order
of birth

Legiti-
mate?

yes.

Date of
birth

6-7

1925-

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth

6

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER
Joe Jones

RESIDENCE

Malad

COLOR

white

AGE AT LAST
BIRTHDAY

49
(Years)

BIRTHPLACE

Malad Ida

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER
Diana Davis

RESIDENCE

Malad

COLOR

white

AGE AT LAST
BIRTHDAY

45-
(Years)

BIRTHPLACE

Willard Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 12:05 a M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. M. Thomas
MD.

(Physician or midwife)

Address

Malad Ida

Filed

6/30

1925-

J. M. Thomas

Registrar.

Registrar.

1952

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

264-108 040-316

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

JUL 6 1925

S

County of Shoshone

City of Kellogg

No. _____ St. _____

BUREAU OF VITAL STATISTICS

Registration District No. 123

File No. 133033

Hospital _____ Primary Registration District No. 2201

Registered No. 110

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>6</u> <u>8</u> <u>1925</u> (Month) (Day) (Year)
--------------------------	---	-----------	--------------------------------	------------------------	---

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 3 ... Number of child of this mother now living, including present birth... 1 ...

FATHER
FULL NAME George Hodgens
RESIDENCE Kellogg Ida
COLOR white AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Wood
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Ellen Lawson
RESIDENCE Kellogg Ida
COLOR white AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Wash
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still Born at 3 P M. on the date above stated. (Born alive or stillborn)

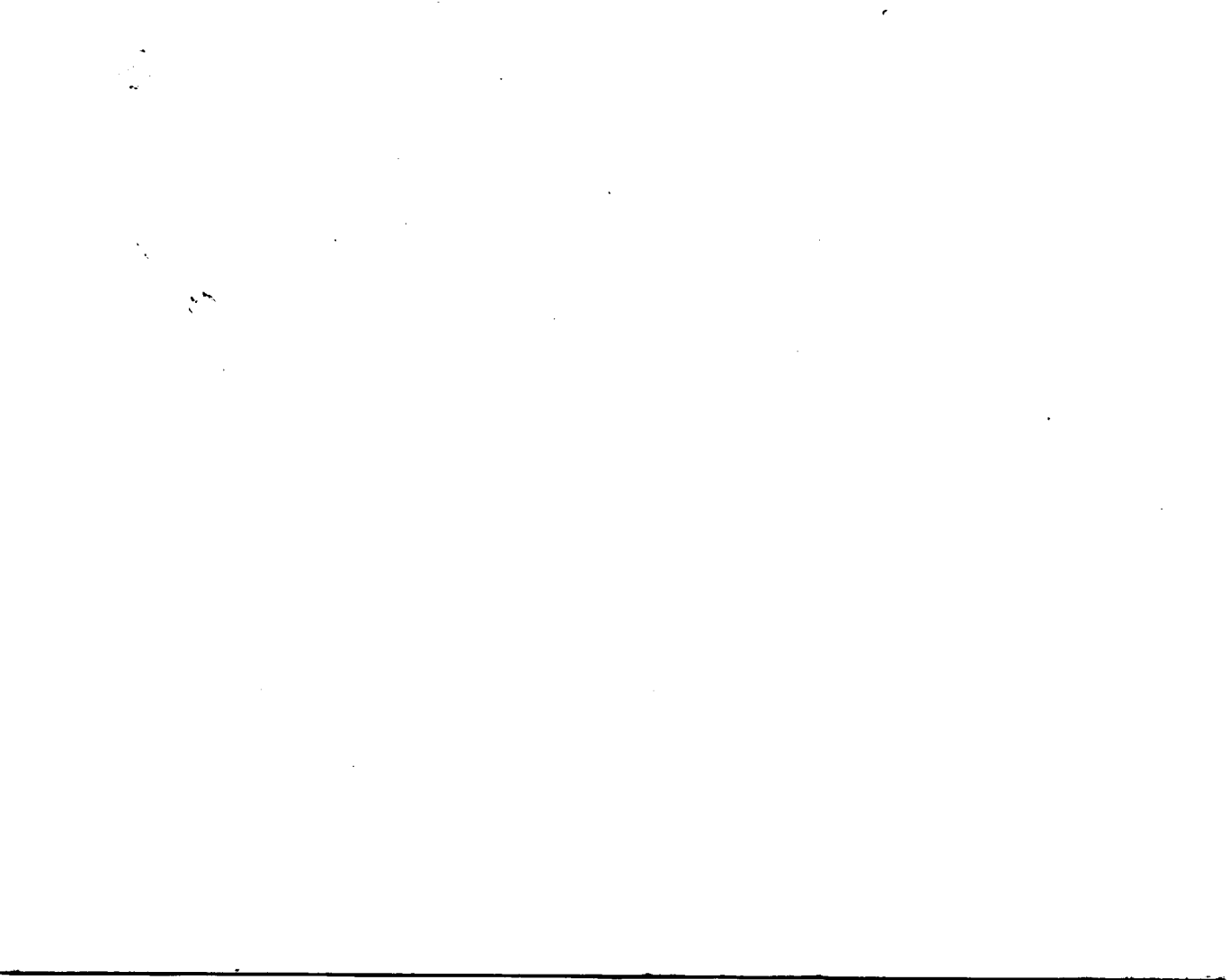
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. C. Ferguson
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Kellogg Ida
Filed June 30 1925 Mrs. Helen M. Beale
Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO		DEPARTMENT OF PUBLIC WELFARE		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS	
753-109 440-417		RECEIVED		JUL 13 1925		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS	
County of <u>Washington</u>		City of <u>Wallace, Ida.</u>		No. <u>70</u>		St. <u>70</u>		Registration District No. <u>1011</u>		State File No. <u>133049</u>		Local Registrar's No. <u>28</u>	
Hospital <u>Providence</u>		Primary Registration		District No. <u>1011</u>		Local Registrar's No. <u>28</u>		FULL NAME OF CHILD <u>Stillborn</u>		(Certificate <u>no value without full name of child</u>)			
Sex of Child <u>Male</u>		Twin Triplet or other? <u>1</u>		and { Number in order of birth <u>5</u>		Legitimate? <u>Yes</u>		Date of birth <u>6-9-1925</u>		(Month) (Day) (Year)			
What bactericidal solution was used in eyes? <u></u>													
Number of child of this mother, including present birth <u>5</u> Number of child of this mother now living, including present birth <u>2</u>													
FATHER				MOTHER									
FULL NAME <u>Joseph Ballisier</u>				FULL MAIDEN NAME <u>Catherine Majors</u>									
RESIDENCE <u>Mullan, Ida.</u>				RESIDENCE <u>Mullan</u>									
COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>39 yrs.</u>				COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>33 yrs.</u>									
BIRTHPLACE <u>Italy</u>				BIRTHPLACE <u>Italy</u>									
OCCUPATION <u>Miner</u>				OCCUPATION <u>Housewife</u>									
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*													
I hereby certify that I attended the birth of this child, who was { <u>Born alive</u> } at <u>10:00 A. M.</u> on the date above stated.													
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }													
Give names added from a supplemental report. <u></u> , 192 <u>5</u>													
Registrar. <u>W. L. Johnson</u>													
Address <u>Wallace, Idaho</u>													
Filed <u>Jan 19 1925</u> Registrar. <u>W. L. Johnson</u>													

13003

CERTIFICATE OF BIRTH

State of _____

County of _____

Primary Registration Number _____

Birth Date _____

Birth Time _____

Sex of Child _____

Weight _____

Length _____

Head _____

Birth _____

Month _____

Day _____

Year _____

Signature _____

Date _____

What particular relation was used in case?

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

FATHER

FULL NAME _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY (Years) _____

BIRTHPLACE _____

OCCUPATION _____

MOTHER

FULL NAME _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY (Years) _____

BIRTHPLACE _____

OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was _____ at _____ on the date above stated.

When there was no attending physician or midwife then the father, mother, etc. should make this report. A newborn child is one that neither has been nor shows other evidence of being born.

Give name and address of a professional report _____

Address _____

Filed _____

1925

When there was no attending physician or midwife then the father, mother, etc. should make this report. A newborn child is one that neither has been nor shows other evidence of being born.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO		S
445 113 040-695		DEPARTMENT OF PUBLIC WELFARE		
County of <u>Walla</u>		BUREAU OF VITAL STATISTICS		
City of <u>Walla</u>		BUREAU OF VITAL STATISTICS		
No.	St.	Register District No.	State File No.	133057
Hospital <u>Pratt</u>		Primary Registration District No. <u>22</u>		Local Registrar's No. <u>23</u>
FULL NAME OF CHILD <u>Stillborn</u>				
(Certificate of no value without full name of child)				
Sex of Child	Twin Triplet or other?	Number in order of birth	Leg. mate	Date of birth
<u>Male</u>	<u>1</u>	<u>2</u>	<u>Yes</u>	<u>5-13-25</u> 1925
				(Month) (Day) (Year)
What bactericidal solution was used in eyes? <u>no</u>				
Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>1</u>		
FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER	
<u>W. Wallace</u>	<u>W. Wallace</u>	<u>Louise</u>	<u>W. Wallace</u>	
RESIDENCE	RESIDENCE	RESIDENCE	RESIDENCE	
<u>Walla, Ida.</u>	<u>Walla, Ida.</u>	<u>Walla, Ida.</u>	<u>Walla, Ida.</u>	
COLOR	AGE AT LAST BIRTHDAY	COLOR	AGE AT LAST BIRTHDAY	
<u>W</u>	<u>41 yrs</u>	<u>W</u>	<u>30 yrs</u>	
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	
<u>Georgia</u>	<u>Georgia</u>	<u>Idaho</u>	<u>Idaho</u>	
OCCUPATION	OCCUPATION	OCCUPATION	OCCUPATION	
<u>Farmer</u>	<u>Farmer</u>	<u>Housewife</u>	<u>Housewife</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*				
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>3:30 P.</u> M. on the date above stated.				
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.				
Give names added from a supplemental report.				
, 192				
Registrar.		Registrar.		

1947

Hospital No. _____
 Location of Birth _____
 Date of Birth _____
 Sex _____
 Weight _____
 Length _____
 Head _____
 Chest _____
 Arm _____
 Leg _____
 Feet _____
 Fingers _____
 Toes _____
 Birthmarks _____
 Other _____
 Signature of Physician _____
 Date _____

Name of Mother _____
 Name of Father _____
 Address of Mother _____
 Address of Father _____
 Date of Birth _____
 Place of Birth _____
 Occupation of Mother _____
 Occupation of Father _____
 Signature of Physician _____
 Date _____

Certificate of Attending Physician of Midwife
 I hereby certify that I attended the birth of this child, who was born on _____ at _____
 Signature of Physician _____
 Date _____
 Address of Physician _____
 Signature of Midwife _____
 Date _____
 Address of Midwife _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
619 105-291
County of Shoshone
City of Wallace, Idaho
No. _____ St. _____ District No. 70 State File No. 133059
Hospital Providence Primary Registration District No. 1211 Local Registrar's No. 21
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
JUL 13 1925
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
CERTIFICATE OF BIRTH

FULL NAME OF CHILD _____
(Certificate of no value without full name of child)
Sex of Child Male Twin Triplet or other? 1 and { Number in order of birth 2 } Legitimate? yes Date of birth May 5 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1
FATHER MOTHER
FULL NAME Hugh A. Warren Bulah Brand
RESIDENCE Idaho Idaho
COLOR White AGE AT LAST BIRTHDAY 27 yrs. White AGE AT LAST BIRTHDAY 20 yrs.
BIRTHPLACE Washington Idaho
OCCUPATION Maternal Housewife

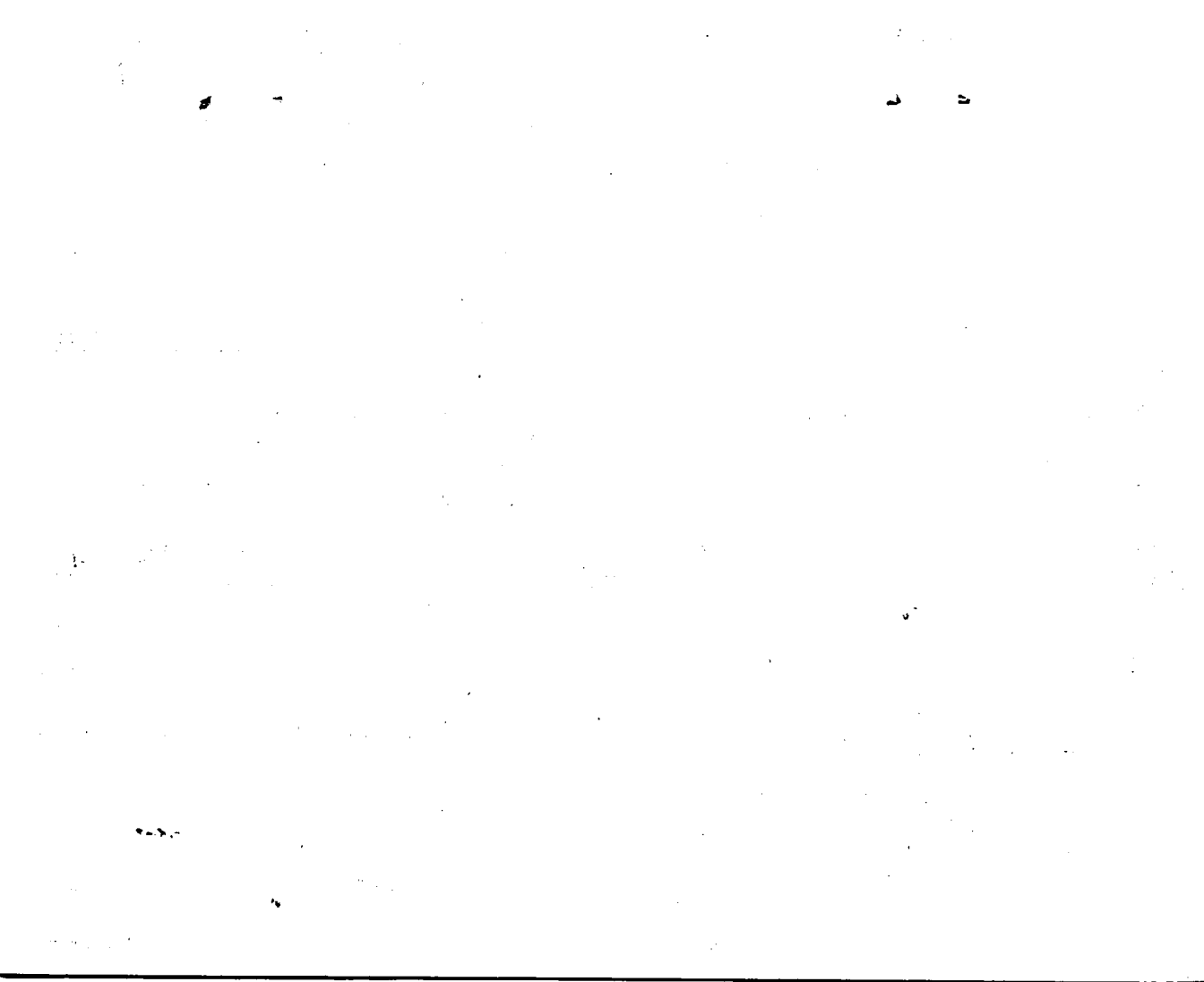
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:00 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1925

(Signature) D. P. W. G. G. G.
(Physician or midwife)
Address Wallace, Idaho
Filed May 15 1925 F. L. L. L.
Registrar. Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Shoshone*

City of *Wallace*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of Hugh Warren

RECEIVED CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *50120*

Local Registrar's No. *72*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

single
(Write the word)

6. DATE OF BIRTH

May 5 1925
(Month) (Day) (Year)

7. AGE

stillborn

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Hugh Warren

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Bulah B Braud

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hugh Warren

(Address)

Idaho

15.

Filed

May 6

1925

F L Duncanson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

1895

16. DATE OF DEATH

May 2 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to *19*

that I last saw him alive on *19*

and that death occurred on the date stated above, at *50* M.

The CAUSE OF DEATH* was as follows:

*Prematurity
2 2 mo.
stillborn*
(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. M. J. Wells

1925 (Address)

State the Disease Causing Death; or in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace

DATE OF BURIAL

May 6 1925

20. UNDERTAKER

W. J. Morrell

ADDRESS

Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train**—accident; **Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-225-20-2

S

County of... Shoshone

JUL 13 1925

BUREAU OF VITAL
STATISTICSRegistration District No. 70File No. 133072City of... Maese, IdahoNo. 194120040-793No. SiPrimary Registration District No. 1011Registered No. 8

Hospital

FULL NAME OF CHILD

Still born

Sex of Child	<u>Male</u>	Twin Triplet or other?	<u>1</u>	and	Number in order of birth	<u>8th</u>	Legitimate?	<u>yes</u>	Date of Birth	<u>3-20-25</u>
(To be answered only in event of plural births)										
FULL NAME	FATHER <u>E. Walter Arms</u>					FULL MAIDEN NAME MOTHER <u>Marion Elsie</u>				
RESIDENCE	<u>Maese, Idaho</u>					RESIDENCE <u>Maese, Idaho</u>				
COLOR	<u>W</u>	AGE AT LAST BIRTHDAY		<u>40 yrs</u>		COLOR		<u>W</u>	AGE AT LAST BIRTHDAY <u>33 yrs</u>	
BIRTHPLACE	<u>Michigan</u>					BIRTHPLACE <u>St. Carolina</u>				
OCCUPATION	<u>Miner</u>					OCCUPATION <u>Housewife</u>				

Number of child of this mother, including present birth... 8 ... Number of children of this mother now living, including present birth... 7 ...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... Still born ... at... 1:45 A.M. ... on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Drs. H. H. H. H. H.

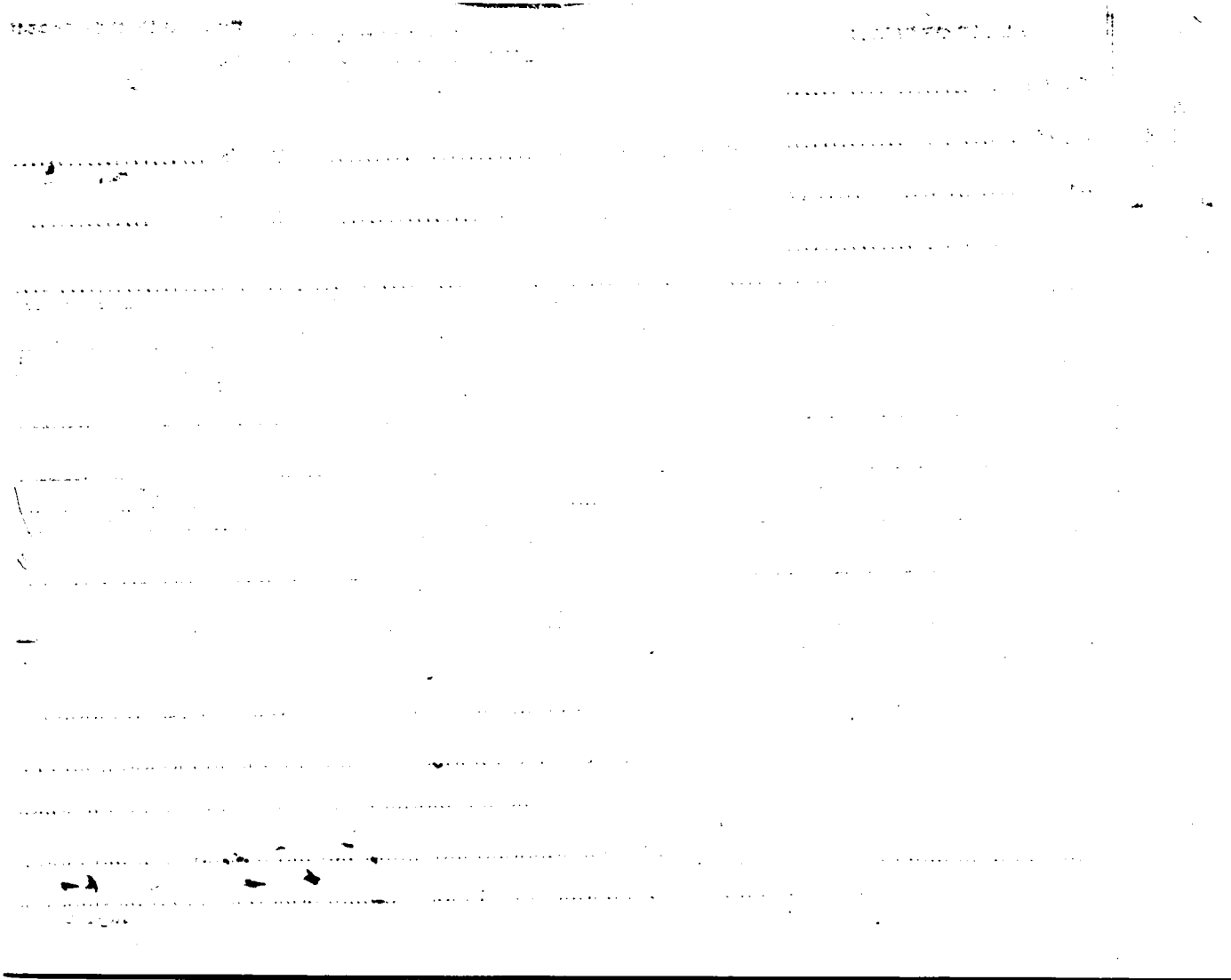
(Physician or midwife)

Given names added from a supplemental report.

Address... Maese, IdahoFiled... Mar. 30, 1925

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V, S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. Idaho (near School)
State File No. 50166
Local Registrar's No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME
Du-fact, of E. W. Arnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
Male

4. COLOR OR RACE
White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED
(Write the word)

6. DATE OF BIRTH
March 20, 1925
(Month) (Day) (Year)

7. AGE
Stillborn
IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER
E. W. Arnes

11. BIRTHPLACE OF FATHER
(State or Country) Michigan

12. MAIDEN NAME OF MOTHER
Mamie Gilstrap

13. BIRTHPLACE OF MOTHER
(State or Country) So Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. W. Arnes
(Address) Mace Idaho

15. March 2, 1925
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 20, 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1925 to 1925,
that I last saw him alive on 1925,
and that death occurred on the date stated above, at 1:45 P.M.
The CAUSE OF DEATH was as follows:
Stillborn
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Signed) [Signature] M. B.
(Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL
Wallace Ida

DATE OF BURIAL
3-21 1925

20. UNDERTAKER
Arnes & Morstall

ADDRESS
Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

28/113 042-366
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

City of Buhl

No. _____ St. _____

Registration District No. 39

File No. 133107

Hospital _____

Primary Registration District No. 2087

Registered No. _____

FULL NAME OF CHILD

(Kaiser) Shaugle

Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>6-13</u> 19 <u>25</u> (Month) (Day) (Year)
------------------------	--	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. _____

FATHER
FULL NAME C. E. Shaugle
RESIDENCE Buhl
COLOR W. AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Ida.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Hora Eschbacher
RESIDENCE Buhl
COLOR W. AGE AT LAST BIRTHDAY 17 (Years)
BIRTHPLACE Calo.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was still born at 1045 a. M.
on the date above stated. (Born alive or stillborn)

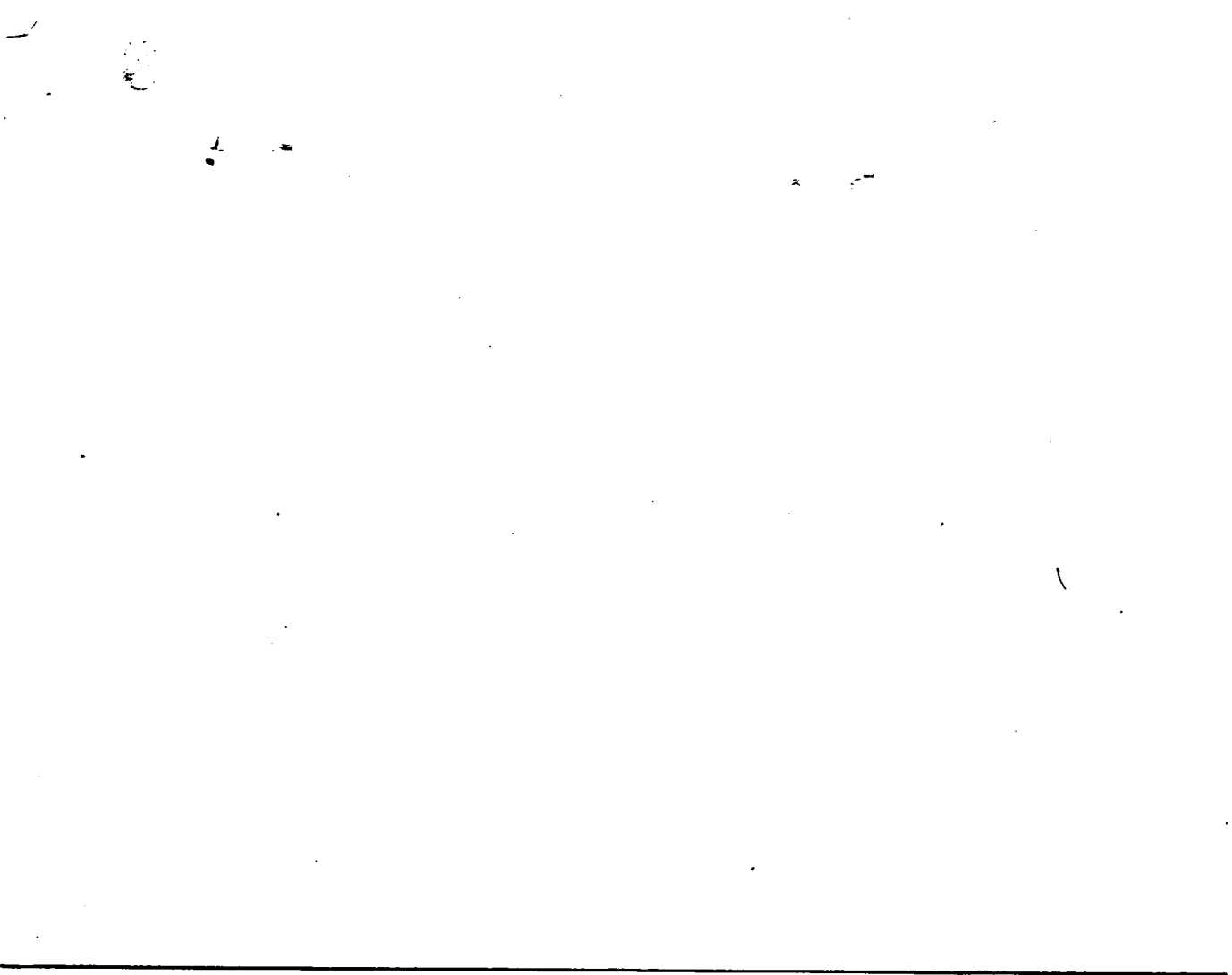
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Murphy
Buhl Ida.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19_____

Registrar.

Address _____
Filed 6-13 1925 J. H. Murphy
Registrar.



RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Summit District No. 39
 City of Basin on District No. 2087
 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Shangle

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 50149
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Write the word

6. DATE OF BIRTH

June 13 1915
 (Month) (Day) (Year)

7. AGE

1 Yrs. 1 Mos. 1 ds.
 IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. Shangle

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Nora Cigentanger

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. Shangle

(Address)

Basin, Idaho

15.

Filed

6-13

1915

J. H. Murphy
 Local Registrar

16. DATE OF DEATH

June 13 1915
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 13 1915, to _____ 19____

that I last saw h. _____ alive on _____ 19____

and that death occurred on the date stated above, at Basin, Idaho

The CAUSE OF DEATH was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory (Secondary) No apparent cause

(Duration) yrs. mos. ds.

(Signed) J. H. Murphy M. D.

6-13-15 (Address) Basin, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Basin Cemetery June 13 1915

20. UNDERTAKER ADDRESS

Murphy & Sons Basin, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

261 042819
PLACE OF BIRTHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

133108

County of Twain FallsCity of Buhl

No. _____ St. _____

Hospital _____

Registration District No. 39

File No.

BUREAU OF VITAL STATISTICS

Primary Registration District No. 2087

Registered No. _____

FULL NAME OF CHILD (None) Swan

(Certificate of no value without full name of child.)

Sex of Child

7.Twin
Triplet
or other?

{ and }

Number
in order
of birthLegiti-
mate?yesDate of
birth6-111925

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth. 1

Number of child of this mother now living, including present birth. _____

FULL
NAME

FATHER

Charlie SwanFULL
MAIDEN
NAME

MOTHER

Velva Hart

RESIDENCE

Buhl

RESIDENCE

Same

COLOR

W.AGE AT LAST
BIRTHDAY22
(Years)

COLOR

W.AGE AT LAST
BIRTHDAY19
(Years)

BIRTHPLACE

Uto.

BIRTHPLACE

Canada

OCCUPATION

Laborer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born at 2:45 a.m.
on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. H. Murphy
M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Buhl Ida.

Filed

6-13 1925J. H. Murphy

Registrar.

Registrar.

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FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Juneau*City of *Buhl*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATHRegistration District No. *39*Explanation District No. *287*

STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. *50150*

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE & SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female* *White* *Single*
(Write the word)

5. DATE OF BIRTH

June *11* *1925*
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds. IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Buhl Idaho*

10. NAME OF FATHER

Charley Swan

11. BIRTHPLACE OF FATHER

(State or Country) *Missouri*

12. MAIDEN NAME OF MOTHER

Velma Stark

13. BIRTHPLACE OF MOTHER

(State or Country) *Canada*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Charley Swan*(Address) *Buhl W.*

15.

Filed *6-11* *1925* *J. H. Murphy*

Local Registrar

MEDICAL CERTIFICATE OF DEATH *189-6*

16. DATE OF DEATH

6 *11* *1925*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6-11 *1925* to *19*that I last saw him alive on *19*and that death occurred on the date stated above, at *3 A.M.*

The CAUSE OF DEATH* was as follows:

Still Born

Contributory (Secondary) *Prolonged Labor, Instrumental Delivery*

(Signed) *J. H. Murphy* M. D.*6-11* *1925* (Address) *Buhl* *Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buhl Ida *June 11* *1925*

20. UNDERTAKER ADDRESS

Johnson *Buhl*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria. (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED		STATE OF IDAHO	
JUL 2 1925		JUL 2 1925		DEPARTMENT OF PUBLIC WELFARE	
BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS	
County of <u>Adair</u>		City of <u>Twin Falls</u>		State File No. <u>133117</u>	
No. <u>419-4</u>		St. <u>Arboret</u>		Registration District No. <u>37</u>	
Hospital		Primary Registration District No. <u>1085</u>		Local Registrar's No.	
FULL NAME OF CHILD		<u>Young</u>		(Certificate of no value without full name of child)	
Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth
<u>male</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>yes</u>	<u>June 10 1925</u>
(To be answered only in event of plural births)					
What bactericidal solution was used in eyes? <u>no</u>					
Number of child of this mother, including present birth <u>1</u> Number of child of this mother now living, including present birth <u>0</u>					
FATHER			MOTHER		
FULL NAME <u>Alton J. Young</u>			FULL MAIDEN NAME <u>Nellie Fay Dudley</u>		
RESIDENCE <u>Twin Falls, Ida</u>			RESIDENCE <u>Twin Falls, Ida</u>		
COLOR <u>white</u>			COLOR <u>white</u>		
AGE AT LAST BIRTHDAY <u>21</u> (Years)			AGE AT LAST BIRTHDAY <u>23</u> (Years)		
BIRTHPLACE <u>Ida.</u>			BIRTHPLACE <u>Ida.</u>		
OCCUPATION <u>carpenter</u>			OCCUPATION <u>Housewife</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*					
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>11 30 P.</u> M. on the date above stated.					
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.					
Give names added from a supplemental report.					
, 192					
Registrar.					
(Signature) <u>Geo. Lauchek m.d.</u>					
Physician (Physician or midwife)					
Address <u>Twin Falls, Idaho</u>					
Filed <u>7-1-25</u> 192 Registrar.					

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF THE COUNTY OF ... AND IS VOID IF THE SIGNATURE IS NOT IN THE SPACE PROVIDED FOR THAT PURPOSE.

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
COUNTY OF ...

CERTIFICATE OF BIRTH

133112

No. ... of ...
County of ...
City of ...
Primary Registration District No. ...
Local Registrar's No. ...

FULL NAME OF CHILD

(Certificate of no living without full name of child)

Sex of child: ☒ Male ☐ Female
Date of birth: (Month) (Day) (Year)
Place of birth: (City) (County) (State) (Country)
To be answered only in case of plural births

What particular relation was used in event?

Number of child of this mother now living, including present birth

Number of child of this mother, including present birth

MOTHER

FATHER

RESIDENCE	COLOR	AGE AT LAST BIRTHDAY (Years)	BIRTHPLACE	OCCUPATION
MOTHER				
FATHER				

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at ... on the date above stated.

When there was no attending physician or midwife, then the father, householder, or neighbor, or other person, who was present at the birth, should make the report. A statement that is one year neither previous nor subsequent to the date of birth. Give names added from a supplemental report.

(Signature)
Address
Filed

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-1
1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of Twin Falls Registration District No. 1085
(No. 419-4th Ave. West St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Nathan J. Young

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 50137
Local Registrar's No. 5356
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS
3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word)
6. DATE OF BIRTH June 10 1925
(Month) (Day) (Year)
7. AGE 0 Yrs. 0 Mos. 0 ds. 0 IF LESS than 1 day how many 0 hrs. or 0 min.?
8. OCCUPATION (a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) 419-4th Ave West
10. NAME OF Father Alton J Young
11. BIRTHPLACE OF FATHER (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Nellie F. Dudley
13. BIRTHPLACE OF MOTHER (State or Country) Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alton Young
(Address) 419-4th Ave West
15. July 1-25 1925 John H. Clanchuk
Local Registrar

MEDICAL CERTIFICATE OF DEATH 1896
16. DATE OF DEATH June 10 1925
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 10 1925 to June 10 1925, that I last saw him alive on stillborn 1925 and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:
stillborn following protracted labor.
(Duration) 0 yrs. 0 mos. 0 ds.
Contributory (Secondary) None
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) John H. Clanchuk M. D.
1925 (Address) Twin Falls, Idaho
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida DATE OF BURIAL 8/11 1925
20. UNDERTAKER J. E. De Witt ADDRESS Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

133146

County of Twin Falls

JUL 2 1925

City of Twin Falls

BUREAU OF VITAL STATISTICS

No. 231-217042459

St. St.

Registration District No. 37

State File No. 133146

Hospital I F Co. Serv.

Primary Registration District No. 1085

Local Registrar's No. 133146

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

female

Twin
Triplet
or other?

}

and {

Number
in order
of birth

}

Legiti-
mate?

yes

Date of
birth

June 17 1925

What bactericidal solution was used in eyes?

NO

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

1

FULL
NAME

FATHER

Frank H. Stapley

RESIDENCE

405-4th Ave E.

COLOR

white

AGE AT LAST
BIRTHDAY

35
(Years)

BIRTHPLACE

Utah

OCCUPATION

Mgr. Murphy Cigar Store

FULL
MAIDEN
NAME

MOTHER

Florie G. Meiner

RESIDENCE

405-4th Ave E.

COLOR

white

AGE AT LAST
BIRTHDAY

37
(Years)

BIRTHPLACE

S. Dakota

OCCUPATION

Hw.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11¹⁰ P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

Dr. J. H. Louch
Physician
(Physician or midwife)

Address

Twin Falls, Idaho

Filed

July 1 1925

Registrar.

Registrar.

RECEIVED
 JUL 2 1962
 U.S. DEPARTMENT OF JUSTICE
 DIVISION OF INVESTIGATION
 WASHINGTON, D.C. 20535

NAME (Last, first, middle)
 FATHER
 MOTHER
 CHILD

BIRTHPLACE
 BIRTHDAY (Month, day, year)
 OCCUPATION
 RELIGION
 COLOR
 SEX

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, and was attended by _____
 (Signature)
 (Printed name)

This document shall have a legal effect only if it is signed by the attending physician or midwife.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of **Twin Falls** Registration District No. **37**

City of **Twin Falls** Registration District No. **1085**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Stapley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

June 17 1925

(Month)

(Day)

(Year)

7. AGE

0

0

0

Yrs.

Mos.

ds.

IF LESS than 1 day how many

hrs. or

min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

###

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

F H Stapley

11. BIRTHPLACE

OF FATHER

(State or Country)

Utah

12. MAIDEN NAME

OF MOTHER

Flossie Miser

13. BIRTHPLACE

OF MOTHER

(State or Country)

So D

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. H. Stapley

(Address)

504 4th Ave East

15.

Filed

July 1-25-19 John P. [Signature]

Local Registrar

RECEIVED CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

50142

Local Registrar's No.

1361

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

17

1925

19

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 17 1925 to June 17 1925
that **she was stillborn**

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

was stillborn following long protracted labor - breech presentation

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

[Signature] M. D.

19

(Address) **Twin Falls, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls Idaho

DATE OF BURIAL

6-19-1925

20. UNDERTAKER

P. J. Grossman

ADDRESS

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

OF IDAHO

PUBLIC WELFARE

ITAL STATISTICS

S

County *Ada*City of *Bonanza*

STATISTICS

DATE OF BIRTH

No. *419 126001 469*St. Registration District No. *2*State File No. *133230*Hospital *2810 W. Baumgardner*Primary Registration District No. *1907*Local Registrar's No. *153*

FULL NAME OF CHILD

(Baby) Darleing (Stillborn not named)
(Certificate of no value without full name of child.)

Sex of Child

*M*Twin
Triplet
or other?*1*

and

Number
in order
of birth*1*

Legitimate?

Yes

Date of birth

*7-26**1925*

(To be answered only in event of plural births)

What bactericidal solution was used in eyes?

No

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

5

FULL NAME

FATHER Clay Darleing

FULL MAIDEN NAME

MOTHER Lula Morgan

RESIDENCE

2810 Baumgardner

RESIDENCE

Bonanza Idaho

COLOR

wh

AGE AT LAST BIRTHDAY

37

(Years)

COLOR

wh

AGE AT LAST BIRTHDAY

38

(Years)

BIRTHPLACE

Kansas

BIRTHPLACE

Kansas

OCCUPATION

Poultry dealer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive

Stillborn

6 P M

on the date above stated.

(Signature)

S. J. Morgan

(Physician or midwife)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Address

Filed

7-31

1925

R. N. Pratt

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

[illegible]

52000000

261

Projet International de la Mer Méditerranée 1973

Life after death.

A stillborn child is one that

...or midway, then the ...

The date above stated.

I hereby certify that I attended the birth

CERTIFICATE OF

... ..

10-10-68

100-443887-100

AGE 11 1/2

1. The first group of respondents (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The second group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The third group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The fourth group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The fifth group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The sixth group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The seventh group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The eighth group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The ninth group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting. The tenth group (n = 10) was composed of students who had completed the course and were currently employed in a health care setting.

SECRET

NAME

10-10-68

[illegible]

have all been now completely inhibited and

1154 10 10
m ync bawana ady T)

ni hua

[illegible]

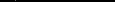
.....**UNITED TO SERVE AM**.....

747171-10

1951 12

10. 2

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



STATE OF NEW YORK

State Of Idaho
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, AUG 15 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

RECEIVED

BUREAU OF VITAL STATISTICS AUG 21 1925

**BUREAU OF VITAL
STATISTICS**

Place of Birth	CITY	<u>Boise</u>	FILE NO.	<u>133230</u>
	ST.	<u>Idaho</u>	DATE OF BIRTH	<u>July 26-1925</u>
	COUNTY	<u>Ada</u>	SEX OF CHILD	<u>Male</u>
	FATHER	<u>Clay Darling</u>	MOTHER	<u>Ruth Morgan</u> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

The child was dead at birth
and not named Clay Darling
Signature of Father or ~~Mother~~

State of Idaho

DEPARTMENT OF PUBLIC WELFARE

Form 100-1 (1937)

The name of your baby was not filed in the birth record because it is of vital importance to the State that names be added in the birth record. If the information requested in this blank is not returned, the earliest convenience in the future will be required.

BUREAU OF VITAL STATISTICS

Place of Birth	of	COUNTY	CITY	1937
FATHER		MOTHER		SEX OF CHILD
(Maiden Name)		DATE OF BIRTH		1937

I HEREBY CERTIFY that the child herein described has been named as follows:

Signature of Father or Mother

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. 2
BUREAU OF VITAL STATISTICS
10. W. Bannock

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 50187
Local Registrar's No. 178

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Darling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

6. DATE OF BIRTH July 26 1925
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF Father Clay Darling

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Lula Morgan

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clay Darling
(Address) 2810 Bannock

15. 7-31-25 19

Filed 7-31-25 19
Local Registrar R. H. Pratt

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 26 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1925 to July 26 1925
that I last saw him alive on July 26 1925
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Still born
(Full term)
(Duration) yrs. mos. ds.
Contributory Cord around neck
(Secondary) no doctor present
(Duration) yrs. mos. ds.
(Signed) D. S. Sweeney M. D.
27 1925 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days, State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Morris Hill Cemetery July 27 1925

20. UNDERTAKER ADDRESS
Drummers & Krebs Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman, "Manager, "Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers, who receive a definite salary,** may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**") **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia,**" unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, "Anaemia**" (merely symptomatic), "**Atrophy, "Collapse, "Coma, "Convulsions, "Debility, "Congenital, "Senile, etc., "Dropsy, "Exhaustion, "Heart Failure, "Hemorrhage, "Inanition, "Marasmus, "Old age, "Shock, "Uraemia, "Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH
799 24044843

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of *Washington*

City of *Wenatchee*

No. _____ St. _____

Registration District No. *86*

File No. *133185*

Hospital _____

Primary Registration District No. *1010*

Registered No. *37*

FULL NAME OF CHILD

Still born X

(Certificate of no value without full name of child.)

Sex of Child

girl

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

(May) 11 1925

(To be answered only in event of plural births)

(Month) (Day) (Year)

Was bactericidal solution used in eyes?

Silver nitrate

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FULL
NAME

FATHER

Frank Gossel-Pringle

FULL
MAIDEN
NAME

MOTHER

Quanita Grace Hutchins

RESIDENCE

Wenatchee Ida

RESIDENCE

Wenatchee Ida

COLOR

White

AGE AT LAST
BIRTHDAY

28

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

27

(Years)

BIRTHPLACE

Mo.

BIRTHPLACE

Kan

OCCUPATION

Merchant

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... *Stillborn*... at... *11*... a M.
on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

F. A. Schmidt
Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Wenatchee Idaho

Filed

June 14 1925

M. R. Hamilton

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Washington Registration District No. _____
City of Wenatchee Primary Registration District No. _____
St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Pringle

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49802Local Registrar's No. 64

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

May 4 1925
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day how many
_____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Frank Pringle

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Grace Hutchins

13. BIRTHPLACE OF MOTHER

(State or Country) Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Pringle(Address) Wenatchee Ida.

15.

Filed 5/5/1925 VR. Hamilton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 4 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1925 to May 4 1925,

that I last saw h. _____ alive on _____ 19____,

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Still Born (Fet. Nature)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. A. S. M. D.5-4-1925 (Address) Wenatchee Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted _____
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hillcrest Cemetery 4/5 1925

20. UNDERTAKER

ADDRESS

Northam McCaw Wenatchee Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

RECEIVED

JUL 17 1925

CERTIFICATE OF BIRTH

City of Pocatillo

No. 4087 Fair St.
399-216003-234

BUREAU OF VITAL
STATISTICS

District No. 38

State File No.

133250

Hospital

Primary Registration District No. 2161

Local Registrar's No. 7071

FULL NAME OF CHILD

No name

(Certificate of no value without full name of child)

Sex of
Child

7

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

6-16

1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 8

Number of child of this mother now living, including present birth 6

FULL
NAME

FATHER

Arthur W Lipp

RESIDENCE

Pocatillo

COLOR

W

AGE AT LAST
BIRTHDAY

40

(Years)

BIRTHPLACE

Iowa

OCCUPATION

Cellar Packer

FULL
MAIDEN
NAME

MOTHER

Mary Blue

RESIDENCE

same

COLOR

W

AGE AT LAST
BIRTHDAY

32

(Years)

BIRTHPLACE

Kans.

OCCUPATION

huf.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 8:20 9 M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

[Signature]

(Physician or midwife)

Address

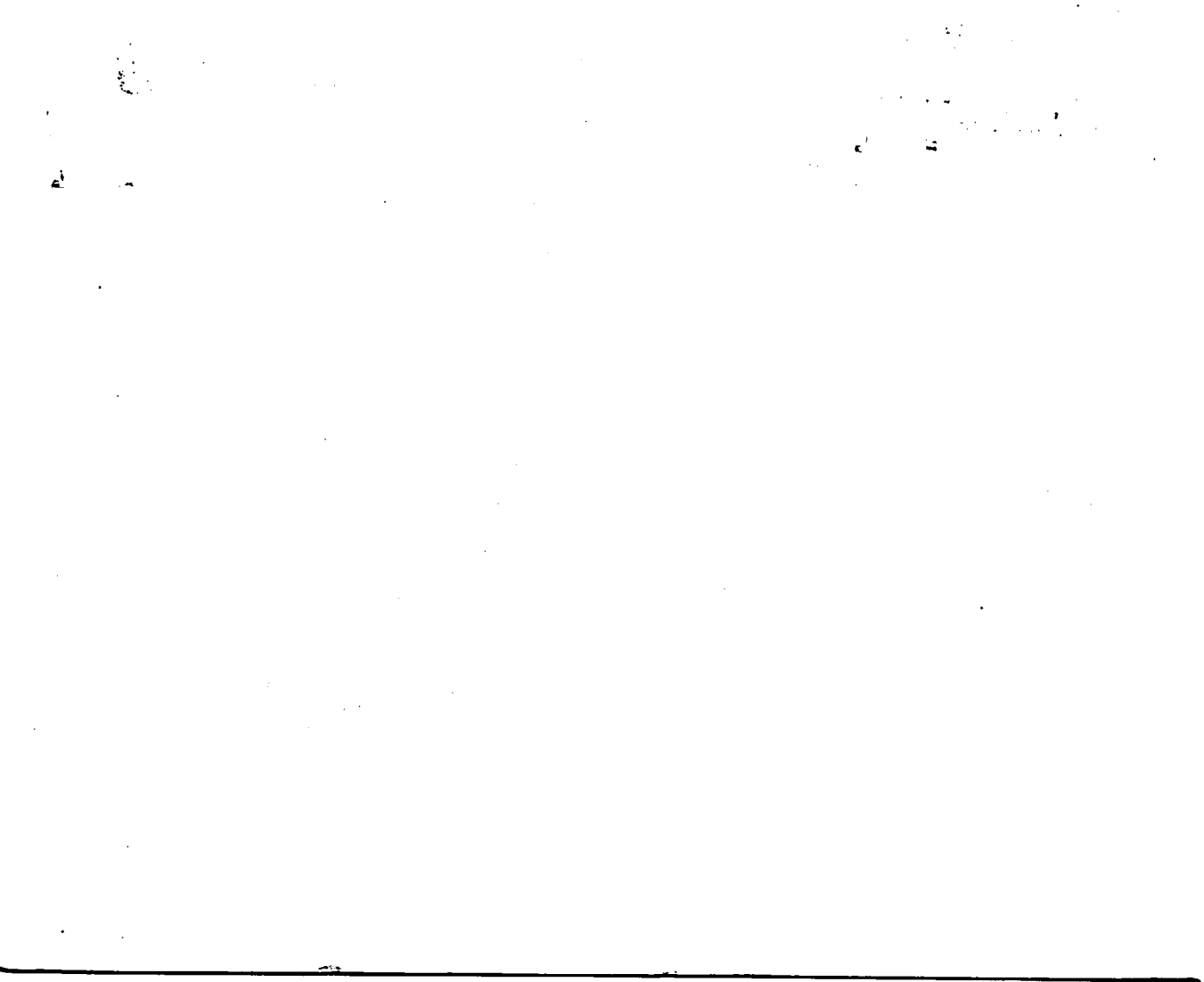
Pocatillo

Filed

7/1, 1925

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **RECEIVED** Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of Pocatello (St.)

File No. 50199
Registered No. 4639

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant - Lipp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH

6 - 16 1925
(Month) (Day) (Year)

7. AGE

Still
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello Id.

10. NAME OF FATHER

Arthur W Lipp

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Mary Blue

13. BIRTHPLACE OF MOTHER

(State or Country)

Kans

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

AW Lipp

(Address)

Pocatello

15.

Filed

6/16 1925

W Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 - 16 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born - Cord
in knot - Strangled.
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

6/16 1925 (Address) Pocatello M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MT View6/16 1925

20. UNDERTAKER

ADDRESS

AW LippPocatelloFather

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of BannockCity of Lava Hot SpringsNo. 191230003-893St. Idaho

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 54

State File No.

133292Hospital MunicipalPrimary Registration District No. 2161Local Registrar's No. 162

FULL NAME OF CHILD

Mary Lu Crave

(Certificate of no value without full name of child)

Sex of Child

FemaleTwin
Triplet
or other?

}

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birthJuly 301925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Daniel Willis Crave

RESIDENCE

Lava Hot Springs, Ida

COLOR

WhiteAGE AT LAST
BIRTHDAY27

(Years)

BIRTHPLACE

Ogden Utah

OCCUPATION

CookFULL
MAIDEN
NAME

MOTHER

Amanda Mary Hill

RESIDENCE

Lava Hot Springs, Ida

COLOR

WhiteAGE AT LAST
BIRTHDAY24

(Years)

BIRTHPLACE

Freemont Co. Wyo

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 9:40 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192...

(Signature)

G. A. Rich

(Physician or midwife)

Address

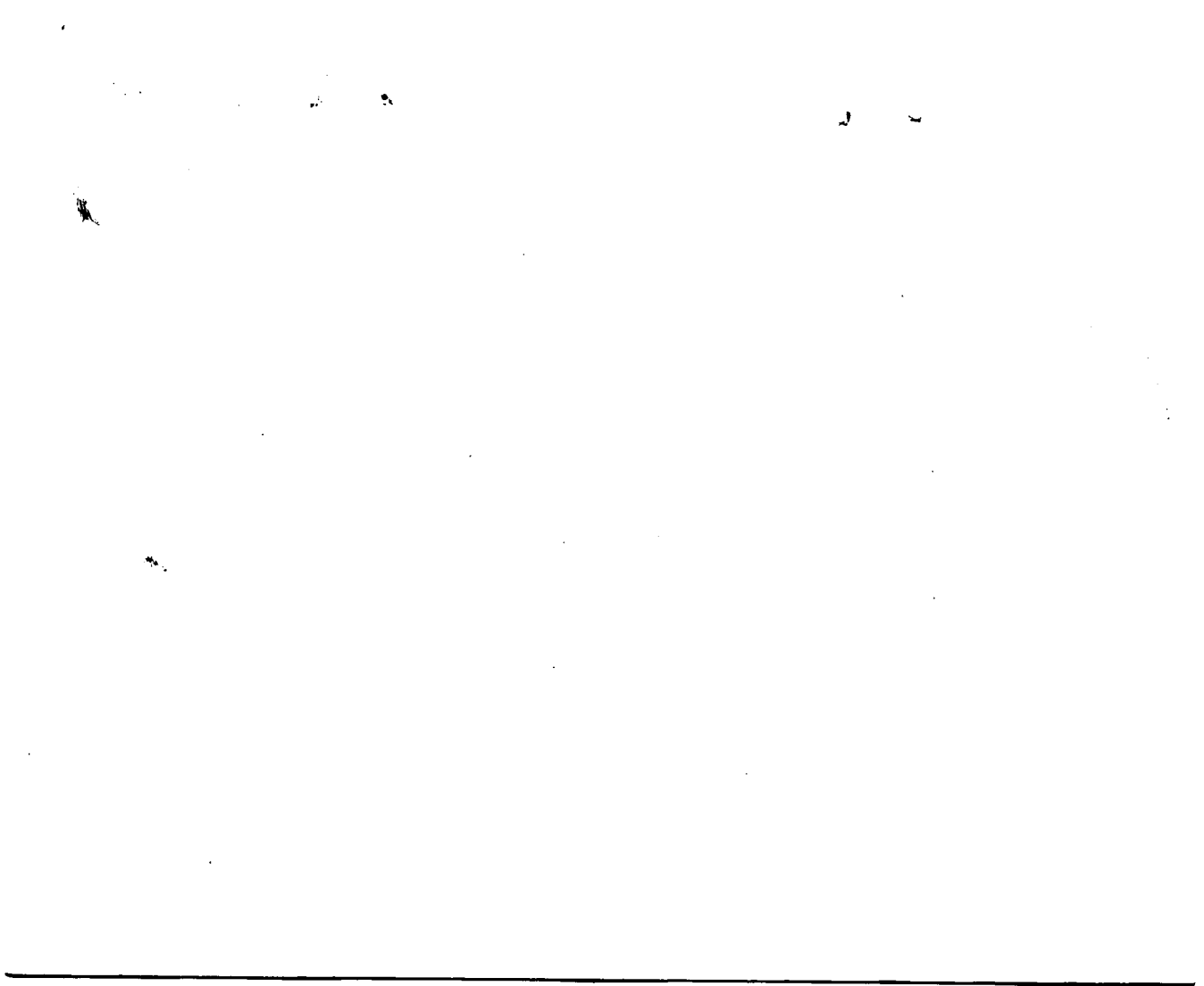
Lava Hot Springs

Filed

Aug 1-1925Mr. J. G. Fitz

Registrar.

Registrar.



1. PLACE OF DEATH

County of Bannock
City of Lava Hot Springs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District 1925Primary Registration District No. 2161No. BUREAU OF STATISTICS St.)RECEIVED
STATE OF IDAHO
AUG 4 1925
BUREAU OF STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 50215Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single (Write the word.)

6. DATE OF BIRTH

July 30 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Bannock Co. Idaho

10. NAME OF FATHER

Daniel Willis Arave

11. BIRTHPLACE OF FATHER

(State or Country) Cyden Utah

12. MAIDEN NAME OF MOTHER

Amanda Mary Hill

13. BIRTHPLACE OF MOTHER

(State or Country) Tremont Co. Wyo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. H. Rich (copy from)(Address) Lava Hot Springs, Idaho

15.

Filed 19

Local Registrar

16. DATE OF DEATH

July 30 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw her alive on No life July 30 1925
and that death occurred on the date stated above, at 7:40 P.

The CAUSE OF DEATH* was as follows:

Stillbirth at about 6 months gestation

(Duration) Yrs. mos. ds.

Contributory Pernicious Vomiting +
(Secondary) toxemia of pregnancy in mother

(Duration) yrs. mos. 7 ds.

(Signed) C. H. Rich M. D.7-30 1925 (Address) Lava Hot Springs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lava Hot Spring Ida 31 1925

20. UNDERTAKER

Had none. ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

619 203 006 - 315
PLACE OF BIRTH

RECEIVED

AUG 7 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

County of Bingham

City of Blackfoot

No. 1877 St. 8th

Registration District No. 161

State File No. 133333

Hospital -

Primary Registration District No. 106

Local Registrar's No. 224

FULL NAME OF CHILD Billy Farnworth

(Certificate of no value without full name of child)

Sex of
Child

Female

Twin
Triplet
or other?

-

and

Number
in order
of birth

-

Legiti-
mate?

Yes

Date of
birth

July 3

1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9

Number of child of this mother now living, including present birth 7

FULL
NAME

FATHER

George Cyrus Farnworth

RESIDENCE

Blackfoot

COLOR

White

AGE AT LAST
BIRTHDAY

36

(Years)

BIRTHPLACE

Utah

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Eva Isabell Candland

RESIDENCE

Blackfoot

COLOR

White

AGE AT LAST
BIRTHDAY

34

(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 A M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. Beck

(Physician or midwife)

Address

Blackfoot, Ida

Filed

1925

W. Beck

Registrar.

Registrar.

[illegible]

*When there was no attention paid to the matter, the matter would have been left alone. The matter would have been left alone. The matter would have been left alone.

Printed grade sheet not so

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

1. I have no other information regarding the birth of this child, other than that I attended the birth of this child, and was present at the birth of this child.

~~CONFIDENTIAL~~ TO NSAS/NSA/14)

(97117 此数未定)

23071.1

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MOITA40200

REPORT

89403

DATE
BIRTHDAY

BIH7H9LACE

NO. 100

AGE 14 30A
YACHTS

CONCLUSIONS

REF ID: A66384

100

外347.8分

114

ЯЗЫКОМ

10-10-68

Number of child of this mother born living present birth

Wentworth Laboratories has been in

It is the answer to the question of how to

世界

1997

... of ...

-1199-

2-10543

Certificate of no value without full name of child

CLASSIFICATION 1.1.19

ON 1988-01-20 08:00:00

2025 RELEASE UNDER E.O. 14176

10, ११७

RETURN TO ATTORNEY GENERAL

DEPARTMENT OF JUSTICE
BUREAU OF VITAL STATISTICS

DRAG TO DEATH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. T-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

RECEIVED

Registration District No. 2194

City of Blackfoot

AUG 7 1925

St.)

File No. 50230

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

STATISTICAL

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

Single

(Write the word.)

6. DATE OF BIRTH.

July 3 1925
(Month) (Day) (Year)

7. AGE

Spillborn

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Cyrus Farnworth

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eva Isabell Candland

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George C. Farnworth

(Address)

Blackfoot, Ida

15.

Filed

July 4 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1925, to July 3 1925, that I last saw h. ~~Did not see alive~~ ^{about} 9 A.M. and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Collapsed cord and baby was dead when I arrived

Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) W. Beck M. D.

7/3 1925 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Groveland Cemetery

7-4 1925

20. UNDERTAKER

ADDRESS

Cyrus Farnworth

Blackfoot

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Jersey

AUG 6 1925

City of Emmett

BUREAU OF VITAL STATISTICS

No. 489-226023844Registration District No. 6State File No. 133447

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

FemaleTwin
Triplet
or other?

}

and {

Number
in order
of birth

}

Legiti-
mate?yesDate of
birth6261925

(Month) (Day) (Year)

What bactericidal solution was used in eyes? 1%Number of child of this mother, including present birth 2Number of child of this mother now living, including present birth 1FULL
NAME

FATHER

Ota Morris

RESIDENCE

Emmett Ida

COLOR

white

AGE AT LAST

BIRTHDAY

38

(Years)

BIRTHPLACE

Texas

OCCUPATION

R.R. BrakemanFULL
MAIDEN
NAME

MOTHER

Delphia Golden Hudson

RESIDENCE

Emmett

COLOR

white

AGE AT LAST

BIRTHDAY

30

(Years)

BIRTHPLACE

Missouri

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 9 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

R. J. Cummings

(Physician or midwife)

Address

Emmett

Filed

7/7 1925J. S. Reynolds

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED

JUL 8 1925

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 49960

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gen

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June 26 1925
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
. min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Ota Morris

11. BIRTHPLACE OF FATHER

(State or Country) Texas

12. MAIDEN NAME OF MOTHER

Golden Hudson

13. BIRTHPLACE OF MOTHER

(State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Loren W. Smith

(Address) RFD-3. Emmet Ida

15.

Filed 6/29/1925

J. H. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

189-6

16. DATE OF DEATH

June 26 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. H. Emmett M. D.

6/26/1925 (Address) Emmet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Joplin Cemetery

June 26 1925

20. UNDERTAKER

ADDRESS

Paul L. Case

Emmet Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

ENT RECORD
N must be made for
A stated.

WRITE PLAINLY WITH UNFADING INK—
N. B.—In case of more than one child at birth a SEI—
each and the number of each, in order.

389-207028-453
PLACE OF BIRTH *Kootenai*
County of *Kootenai*
City of *Coeur d'Alene*
No. *1011* - *B* St. Register District No. *30* State File No. *133465*
Hospital *Coeur d'Alene* Primary Registration District No. *1051* Local Registrar's No. *1347*
FULL NAME OF CHILD *Mary Grace Christensen*
(Certificate of no value without full name of child)

Sex of Child *Female* Twin Triplet or other? *one* and { Number in order of birth *one* Legitimate? *yes* Date of birth *May 7* 192*5*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? *none*

FATHER		MOTHER	
Number of child of this mother, including present birth <i>2</i>	Number of child of this mother now living, including present birth <i>1</i>	FULL MAIDEN NAME <i>Grace Delmar</i>	FULL NAME <i>Chris J. Christensen</i>
RESIDENCE <i>Coeur d'Alene</i>	RESIDENCE <i>Coeur d'Alene</i>	COLOR <i>white</i>	COLOR <i>white</i>
AGE AT LAST BIRTHDAY <i>42</i> (Years)	AGE AT LAST BIRTHDAY <i>32</i> (Years)	BIRTHPLACE <i>Norway</i>	BIRTHPLACE <i>Wisconsin</i>
OCCUPATION <i>Mill Man</i>	OCCUPATION <i>Housewife</i>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { *Born alive* } at *4:30 P. M.* on the date above stated. { *Stillborn* }

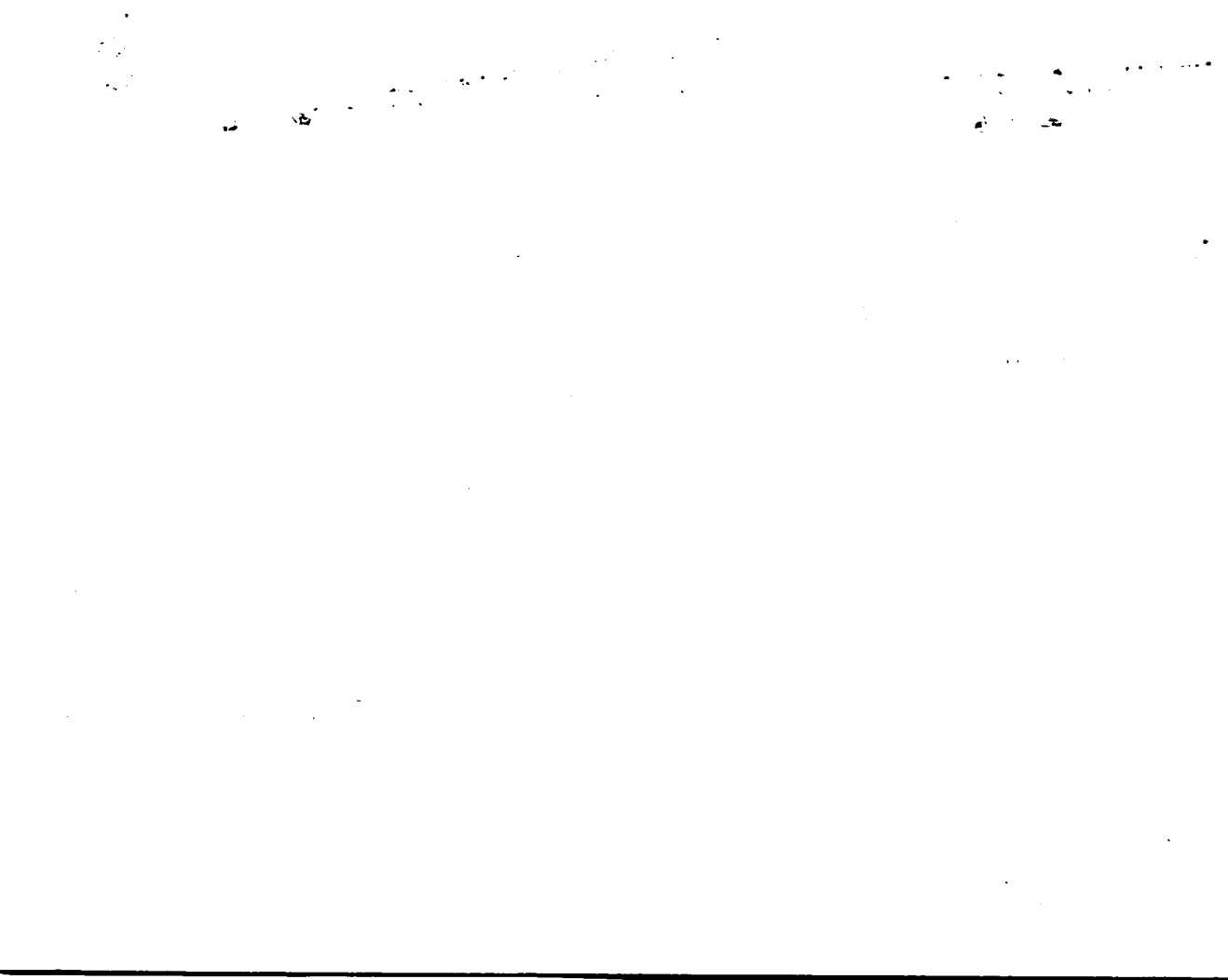
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. , 192

(Signature) *W. H. Kaeder*
Physician
(Physician or midwife)

Address *Coeur d'Alene*

Filed *Aug 4 1925* - *W. B. Brame*
Registrar. Registrar.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Poston District No. 3
City of Coeur d'Alene Registration District No. 1051
(No. Coeur d'Alene 1st St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Inf. Christensen

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 49621
Local Registrar's No. 1521

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

May 7 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
— hrs. or
— Yrs. — Mos. — ds. — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

C. J. Christensen

11. BIRTHPLACE OF FATHER

(State or Country) Norway

12. MAIDEN NAME OF MOTHER

Grace Blish

13. BIRTHPLACE OF MOTHER

(State or Country) Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. J. Christensen
(Address) Coeur d'Alene Ida.

15. D. D. DRENNAN, M. D.

Filed JUN 4 1925 19 OFFICE 210 HARDING BLOCK
COEUR D'ALENE Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 7 1925 to May 7 1925,
that I last saw him alive on May 7 1925,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Still born

(Duration) — yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

M. H. Hoedner M. D.
1925 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place — yrs. — mos. — days. In the State — yrs. — mos. — ds.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest

DATE OF BURIAL

19

20. UNDERTAKER

R. B. Mooney

ADDRESS

Coeur d'Alene
Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

963-115-029-769

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah AUG 6 1925

City of Moscow, BUREAU OF VITAL
STATISTICS

No. 845 E. 7th St. Registration District No. 101

File No. 133494

Hospital _____ Primary Registration District No. 1011 Registered No. 83

FULL NAME OF CHILD Milton Eugene Rollefson

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> { and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth... <u>June 15</u> ... 192 <u>5</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FATHER
FULL NAME Eugene Dennis Rollefson

RESIDENCE Moscow, Ida.

COLOR White AGE AT LAST BIRTHDAY 31
(Years)

BIRTHPLACE Granite Falls, Min.

OCCUPATION Dentist

MOTHER
FULL MAIDEN NAME Charlotte Ella Poindexter

RESIDENCE Moscow, Ida

COLOR White AGE AT LAST BIRTHDAY 24
(Years)

BIRTHPLACE Farmington, Wash

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 9:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. Harry Eishaus
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Moscow, Ida.
Filed July 25 1925 M. Harithers
Registrar.

2

AUG 27 1962

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Latah*
City of *Moscow*

RECEIVED

JUL 13 1925

BUREAU OF VITAL
STATISTICSRegistration District No. *61*
Registration District No. *1011* St.)File No. *50006*
Registered No. *33*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Malton Eugene Rollefson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Child*
(Write the word.)

6. DATE OF BIRTH

June (Month) *15* (Day) *1925* (Year)

7. AGE

*Stillborn*IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Eugene Rollefson

11. BIRTHPLACE OF FATHER

(State or Country) *Minn.*

12. MAIDEN NAME OF MOTHER

Charlotte Prindexter

13. BIRTHPLACE OF MOTHER

(State or Country) *Wash.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Eugene Rollefson*
(Address) *Moscow, Idaho*

15.

Filed *June 16* 1925 *M. Caruthers*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) *15* (Day) 19 *25* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Stillborn 6/15/25 4:30 P.M. Heart was not functioning at birth due I believe to constriction cord during breech delivery using forceps on head. I opened baby in a primipara of small pelvic measurements.
(Duration) (yrs.) (mos.) (ds.)
(Signed) *Harry Enchous* M. D.
6/16/25 (Address) *Moscow, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Farmington Wash.

DATE OF BURIAL

6/16/1925

20. UNDERTAKER

H. R. Short

ADDRESS

Moscow

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of IdahoCity of Deary, Ida.No. 319-21002-1745 St.Registration District No. 64State File No. 133498

Hospital

Primary Registration District No. 2144 Local Registrar's No.

FULL NAME OF CHILD

Baby Carter

(Certificate of no value without full name of child)

Sex of Child

FemaleTwin
Triplet
or other?

}

and {

Number
in order
of birth

{

Legiti-
mate?YesDate of
birthJuly 10th1925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

No

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

6FULL
NAME

FATHER

James Daniel Carter

RESIDENCE

Deary, Ida.

COLOR

WhiteAGE AT LAST
BIRTHDAY32

(Years)

BIRTHPLACE

Tennessee

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Martha Reanyan

RESIDENCE

Deary, Ida.

COLOR

WhiteAGE AT LAST
BIRTHDAY33

(Years)

BIRTHPLACE

Pullman Wash.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 9:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Lucy M. Pickard
July 31, 1925
Registrar.

(Signature)

J. W. Faulkner
Physician
(Physician or Midwife)

Address

Idaho

Filed

July 31, 1925
Lucy M. Pickard
Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

UNION OF AMERICAN WOMEN'S CLUBS, 101 N. 1st St., St. Paul, Minn. 55401
 (to be filled out by the mother or father of the child, or by the physician or midwife attending the birth, or by the nurse or other person in attendance at the birth)

CERTIFICATE OF BIRTH

County of _____ State of _____
 City or Town of _____
 Hospital _____
 Primary Health District No. _____
 (Certificate to be filled out by the mother or father of the child)
 Name of child _____
 Sex of child _____
 Date of birth _____
 Time of birth _____
 Place of birth _____
 Name of mother _____
 Name of father _____
 Name of nurse or other person in attendance _____
 Name of physician or midwife _____

What bacteriological section was used in case?
 Number of child of this mother, including present birth _____
 Number of child of this mother, including present birth _____
 Name of mother _____
 Name of father _____
 Residence _____
 Color _____
 Age at last birthday _____
 Birthplace _____
 Occupation _____
 Birthplace _____
 Color _____
 Age at last birthday _____
 Residence _____
 Name of mother _____
 Name of father _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.
 I hereby certify that I attended the birth of this child, who was _____ at the date above stated.
 (Signature) _____
 Address _____
 Filed _____
 If the mother or father of the child is deceased, the certificate shall be signed by the physician or midwife attending the birth, or by the nurse or other person in attendance at the birth.
 If the mother or father of the child is deceased, the certificate shall be signed by the physician or midwife attending the birth, or by the nurse or other person in attendance at the birth.
 If the mother or father of the child is deceased, the certificate shall be signed by the physician or midwife attending the birth, or by the nurse or other person in attendance at the birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Idaho*City of *Idaho Falls*

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

RECEIVED

District No. *64*Primary Registration District No. *2144*

BUREAU OF VITAL STATISTICS

2. FULL NAME

*Stillborn (Baby Carter)*STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. *50308*

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

July 10th 1925
(Month) (Day) (Year)

7. AGE

*Stillborn*IF LESS than 1 day how many
.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho, Ida.*

10. NAME OF

Father *James Daniel Carter*

11. BIRTHPLACE OF FATHER

(State or Country) *Tennessee*

12. MAIDEN NAME OF MOTHER

Martha Runyan

13. BIRTHPLACE OF MOTHER

Pullman, Wash.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. W. Faulkner*
(Address) *Idaho, Ida.*

15.

Filed *July 31 1925* *Lucy M. Pickard*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10th 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *July 10th 1925* to *July 10th 1925*
that I last saw her *Unknown*
and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Unknown
*Stillborn*Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. W. Faulkner* M. D.(Address) *Idaho, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Beaulah care

DATE OF BURIAL

July 10 1925

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

942-208003-753
County of Bannock
City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

AUG 15 1925

CERTIFICATE OF BIRTH

No. ✓ St. Bureau of Vital Statistics Registration District No. 28 State File No. 133713
Hospital Pocatello General Primary Registration District No. 2181 Local Registrar's No. 2129

FULL NAME OF CHILD

Betty Lou Rush

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? ✓ and { Number in order of birth } Legitimate? yes Date of birth July 8 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER

FULL NAME Willard V. RushRESIDENCE Pocatello IdahoCOLOR wht AGE AT LAST BIRTHDAY 23 (Years)BIRTHPLACE IdahoOCCUPATION Musician

MOTHER

FULL MAIDEN NAME Shelma PeckRESIDENCE sameCOLOR wht AGE AT LAST BIRTHDAY 22 (Years)BIRTHPLACE IdahoOCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8³⁰ 4 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. May

(Physician or midwife)

Address Pocatello IdahoFiled 8. 1925

Registrar.

Registrar.

THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF VITAL STATISTICS, STATE OF IDAHO.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

AUG 12 1915 CERTIFICATE OF BIRTH

SUBJECT: District No. _____ State File No. _____

Primary Registration District No. _____ Local Registrar's No. _____

Hospital _____

FULL NAME OF CHILD _____

Sex of Child _____
 (To be answered only in case of twins)
 Was subject? _____
 (To be answered only in case of twins)
 Number of children _____
 (To be answered only in case of twins)

Length of gestation _____
 (Months) _____ (Days) _____ (Years) _____
 Date of birth _____
 (Month) _____ (Day) _____ (Year) _____

What antiseptical solution was used in case _____

Name of child of this mother, including present birth _____

Name of child of this mother, including present birth _____

FULL NAME _____

FATHER _____

FULL NAME _____
 MOTHER _____

RESIDENCE _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY _____ (Years)

COLOR _____

AGE AT LAST BIRTHDAY _____ (Years)

BIRTHPLACE _____

BIRTHPLACE _____

OCCUPATION _____

OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

On the date above stated.
 When there was no attending physician or midwife then the father, householder, etc., should make the return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
 (Give names added from a supplemental report.)

(Physician or midwife)

Address _____

Filed _____

100

100

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
AUG 15 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BannockCity of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby - stillbornRegistration District No. 28Registration District No. 2161No. General HospitalFile No. 50393Registered No. 4644

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

July 8 1925
(Month) (Day) (Year)

7. AGE

StillbornIF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

W. V. Rush

11. BIRTHPLACE OF FATHER

(State or Country)

Pocatello - Ida.

12. MAIDEN NAME OF MOTHER

Helma Peck

13. BIRTHPLACE OF MOTHER

(State or Country)

Malad Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Peck

(Address)

Pocatello

15.

Filed

7/81925J. H. Peck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 8 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillbirth 191.

that I last saw h. alive on 191.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature -
Mother operated for ruptured
apex with tube and every
effort made with removal.
(Duration) yrs. mos. ds.Contributory Sickness of mother (secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Peck M. D.7/8 1925 (Address) Pocatello.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Blackfoot.

DATE OF BURIAL

7/8 1925

20. UNDERTAKER

E. S. Peck

ADDRESS

Blackfoot

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FILE # 133882

YEAR 1925

IDAHO STILLBIRTH CERTIFICATE

☒ VOID DUP OF 1925-132401

2000 2001 2002 2003

2004 2005 2006 2007

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho **RECEIVED**
City of Cottonwood **AUG 17 1925**
No. 212 124 025-356 **BUREAU OF VITAL** **CERTIFICATE OF BIRTH** **133995**
St. STATISTICS District No. 105 State File No. 51

Hospital _____ Primary Registration District No. 2182 Local Registrar's No. 51

FULL NAME OF CHILD George Baker

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? yes Date of birth July 24 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Geo. H. Baker
RESIDENCE Cottonwood
COLOR white AGE AT LAST BIRTHDAY 52
(Years)
BIRTHPLACE Mo.
OCCUPATION Rancher

MOTHER
FULL MAIDEN NAME Mabel Jeff
RESIDENCE Cottonwood
COLOR white AGE AT LAST BIRTHDAY 32
(Years)
BIRTHPLACE Ida.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 7:30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Wesley Orr

(Physician or midwife)

Address Cottonwood Ida.

Filed Aug 1925 W. F. Orringer B.

Registrar.

Registrar

RECEIVED
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERIFICATE OF DEATH

No. 103
Date of Death 10-10-1918
Place of Death 103

Primary Registration District No. 103
County of Hamilton

Age at Death 103
Sex M
Race W
Color W
Birthplace 103
Occupation 103

What immediate condition was used in death?
Cause of death in this manner, including disease, injury, or violence, as far as known, and the manner of death, if known.

Place of birth in this manner, including disease, injury, or violence, as far as known, and the manner of death, if known.

Residence 103
Color 103
Age at last birthday 103

Birthplace 103
Occupation 103

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the death of this child, who was born on the date above stated.

When there was no attending physician or midwife, the death should be reported to the health officer of the city or town in which the death occurred.

Signature of Physician or Midwife
Address

103

RECEIVED
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERIFICATE OF DEATH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of Idaho
City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

July 24 1925
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.

If LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

George H. Baker

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Mabel Jeff

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H. Baker

(Address) Cottonwood

15.

Filed Aug

1925

H. F. Orger
Local Registrar

RECEIVED CERTIFICATE OF DEATH.

AUG 17 1925

BUREAU OF VITAL STATISTICS

Registration District No. 105

Registration District No. 2183

St.)

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

— 191—, to — 191—,
that I last saw h. — alive on — 191—

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Abuptio Placenta
stillborn

(Duration) — Yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Wesley Orr M. D.

7/25/25 (Address) Cottonwood, Mo.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

On home place

DATE OF BURIAL

7/24 1925

20. UNDERTAKER

George H. Baker
Cottonwood

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Kootenai

City of Conrad

SEP 7 1925

CERTIFICATE OF BIRTH

S 134000

No. 759215028851 St.

BUREAU OF VITAL

Registration District No. 30

State File No.

Hospital

Primary Registration District No. 1057

Local Registrar's No. 1370

FULL NAME OF CHILD

Monica Rarick

(Certificate of no value without full name of child)

Sex of Child fr.

Twin
Triplet
or other?

and { Number
in order
of birth

First

Legiti-
mate?

yes.

Date of
birth

July 16 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

No.

Number of child of this mother, including present birth VII

Number of child of this mother now living, including present birth VJ

FULL
NAME

FATHER

Robert G. Rarick

RESIDENCE

Conrad, Ida.

COLOR

Wh.

AGE AT LAST
BIRTHDAY

36

(Years)

BIRTHPLACE

Minn.

OCCUPATION

Met. Laborer.

FULL
MAIDEN
NAME

MOTHER

Annakaly.

RESIDENCE

Conrad

COLOR

Wh.

AGE AT LAST
BIRTHDAY

28

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housew.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10 a. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. H. Hughes

(Physician or midwife)

Address

Conrad, Ida.

Filed

Sept 4

1925

D. D. Green

Registrar

Registrar.

FULL NAME MAJOR NAME RESIDENCE COLOR BIRTHDAY BIRTH DATE OCCUPATION		FULL NAME MAJOR NAME RESIDENCE COLOR BIRTHDAY BIRTH DATE OCCUPATION	
I hereby certify that I attended the birth of this child, who is (Name) at (Address) of (City) on (Date) at (Time)		I hereby certify that I attended the birth of this child, who is (Name) at (Address) of (City) on (Date) at (Time)	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE		CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH **RECEIVED**
County of Boone Registration District No. 30
City of Boone Primary Registration District No. 1051
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Monica Parrick

State File No. 50289
Local Registrar's No. 1349
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

July 15 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. 0 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF
Father Robert Parrick

11. BIRTHPLACE
OF FATHER Minnesota
(State or Country)

12. MAIDEN NAME
OF MOTHER Anna Hiley

13. BIRTHPLACE
OF MOTHER N. Dakota
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna Parrick
(Address) Coeur d'Alene Idaho

15. Filed Aug 4 1925 DD Drama
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Birth Twin

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

7/15/25 (Address) Coeur d'Alene Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Coeur d'Alene Cemetery - Coeur d'Alene 7/15 1925

20. UNDERTAKER

ADDRESS

Co L. Barry Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai

City of Pathtone

No. 386-20028 815

Registration District No. 30

State File No. 134027

Hospital

Primary Registration District No. 1057

Local Registrar's No. 1596

FULL NAME OF CHILD Stefan

(Certificate of no value without full name of child)

Sex of Child female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

August 20, 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes? boric acid

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

Thomas H. Thorp

RESIDENCE

Bayview - Ida.

COLOR

white

AGE AT LAST
BIRTHDAY

46
(Years)

BIRTHPLACE

Calif.

OCCUPATION

Painter

FULL
MAIDEN
NAME

MOTHER

Charlotte F. Hardy

RESIDENCE

Bayview - Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

25
(Years)

BIRTHPLACE

Idaho

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 5:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Frank Mearns

(Physician or midwife)

Address

Pathtone, Idaho

Filed

Sept 4

1925

W. D. Grema

Registrar.

Registrar.



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State Of Idaho

RECEIVED
SEP 17 1925
BUREAU OF VITAL
STATISTICS

DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho,

SEP 9 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

Place of Birth	{	CITY <u>Garwood</u>	FILE NO.	134027
		ST.	DATE OF BIRTH	<u>Aug 20th</u>
		COUNTY <u>Kootenai</u>	SEX OF CHILD	<u>girl</u>
		FATHER <u>John J. Thorpe</u>	MOTHER <u>[REDACTED]</u>	(Maiden Name) <u>Charlotte Morris</u>

I HEREBY CERTIFY that the child herein described has been named:

unnamed - was a still birth

John J. Thorpe
 Signature of Father or Mother.

STATE OF TEXAS

DEPARTMENT OF PUBLIC WELFARE

BOARD OF STATE SERVICES

OFFICE OF THE

ATTORNEY GENERAL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Kootenai*
City of *Bayview*

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

RECEIVED STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Registration No. *30*
District No. *1051*
(No. *unmarried*) *Thorp* St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *50486*
Local Registrar's No. *1360*

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *single*
(Write the word)

6. DATE OF BIRTH *August 20, 1925*
(Month) (Day) (Year)

7. AGE *stillborn* IF LESS than 1
day how many
hrs. or
Yrs. Mos. ds. min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE
(State or Country) *Kootenai County, Idaho*

10. NAME OF
Father *Thomas H. Thorp*

11. BIRTHPLACE
OF FATHER *Calif.*
(State or Country)

12. MAIDEN NAME *Charlotte Morris*
OF MOTHER

13. BIRTHPLACE
OF MOTHER *Kootenai Co. Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Thomas H. Thorp*
(Address) *Bayview - Idaho*

15. Filed *Sept. 7* 1925 *D. D. Druman*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *August 20, 1925*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19 to 19,
that I last saw him alive on 19,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*stillborn - nondevelopment
of cranial bones.*

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Frank Henry* M. D.
1925 (Address) *Cathlamet, Wash.*

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
8/25 1925

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
VITAL STATISTICS

S

County of Reynolds

City of Reynolds

No. 265 731 033 736 St.

Registration District No. 10 0

State File No.

DATE OF BIRTH

134068

Hospital

Primary Registration District No. 2178

Local Registrar's No. 1174

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

}

and

{

Number
in order
of birth
(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

July 31

1925

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5

Number of child of this mother now living, including present birth 3

FULL
NAME

John E. Swendsen

FATHER

RESIDENCE

Reynolds

COLOR

W

AGE AT LAST
BIRTHDAY

49

(Years)

BIRTHPLACE

Utah

OCCUPATION

Farmer

FULL
MAIDEN
NAME

Effie Block

MOTHER

RESIDENCE

Reynolds Ida

COLOR

W

AGE AT LAST
BIRTHDAY

44

(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6:20 9 M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. B. Rigby M.D.

(Physician or midwife)

Address

Filed

8/8

1925

Reynolds

Registrar.

Registrar.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

AUG 12 1925

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison

City of Rephung

(No. _____)

St. _____

If death occurs away from usual residence, give facts called for under special information

2. FULL NAME

Stillborn Baby Sundeen

Registered No. 235

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

Still Born
0 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rephung

10. NAME OF FATHER

John Edward Sundeen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ellen M. Gibbs

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Edward Sundeen

(Address)

Rephung

15.

Filed

7/8

191

25

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 31/1925

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 31 1925, to July 31 1925,

that I last saw him alive on _____ 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

H. B. Rigby M. D.

(Address)

Rephung, Ida

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

..... yrs. mos. days.

In the

State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rephung, Idaho

7/31 191

20. UNDERTAKER

ADDRESS

J. Loun E. Kelle

Rephung

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill*; (a) *Salesman, (b) Grocery*; (a) *Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

134071

County of Mad

City of Thornston

No. 249125033695 St. 3

Hospital

RECEIVED

AUG 12 1925

BUREAU OF VITAL
STATISTICS

Registration No. 100 State File No.

Primary Registration District No. 2178 Local Registrar's No. 1127

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth Legitimate? yes Date of birth July 25 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME James R. Smith

RESIDENCE Thornston Idaho

COLOR W AGE AT LAST BIRTHDAY 38
(Years)

BIRTHPLACE Utah

OCCUPATION Farmers

MOTHER
FULL MAIDEN NAME Pauline Wieland

RESIDENCE Thornston Idaho

COLOR W AGE AT LAST BIRTHDAY 41
(Years)

BIRTHPLACE Germany

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 7:20 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. B. Rigby M.D.

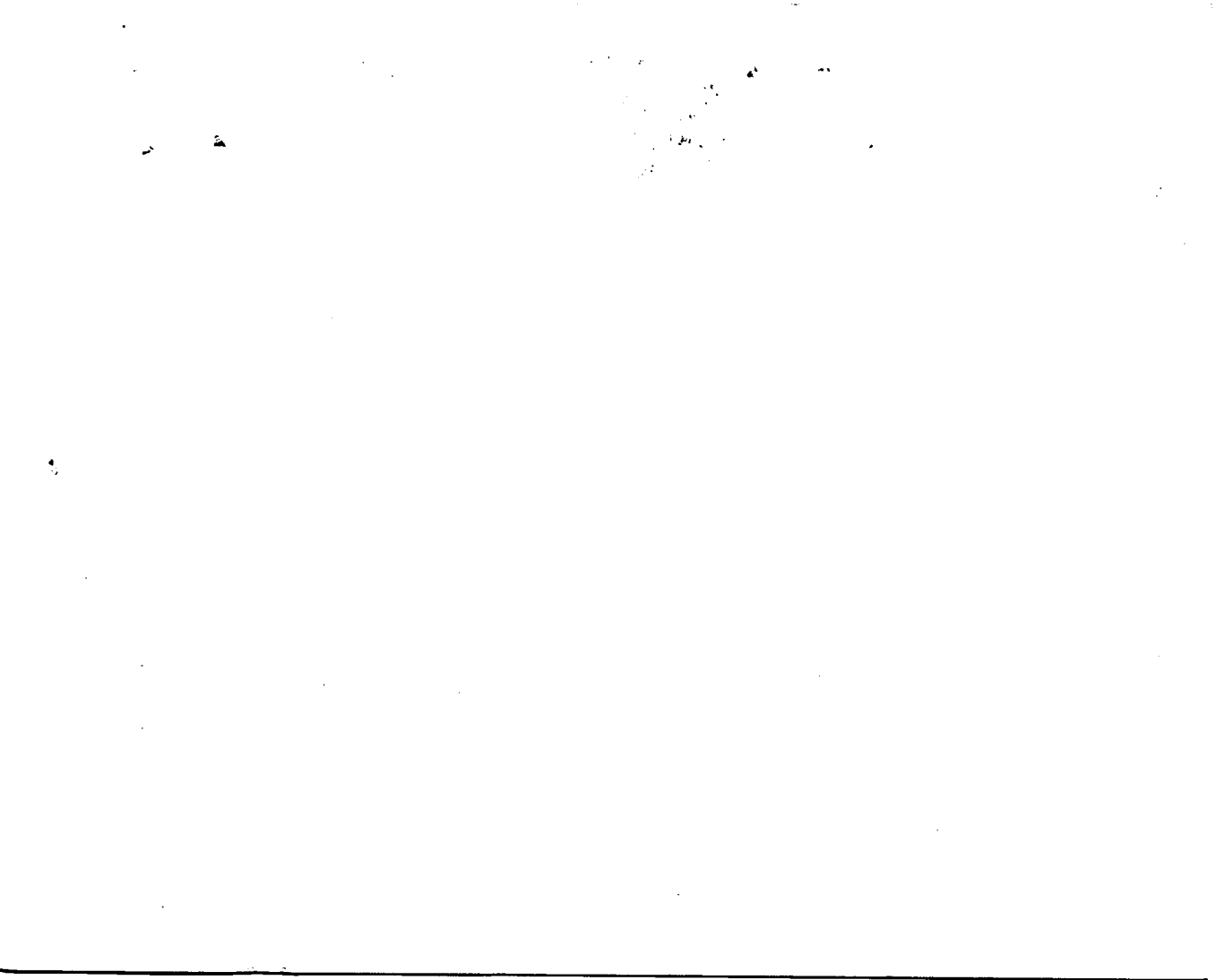
(Physician or midwife)

Address

Filed 8/8 1925 J. B. Remy

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of *Madison*
City of *Rexburg*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

RECEIVED

Registration District No. *100*
Primary Registration District No. *2178*

BUREAU OF VITAL STATISTICS

Baldy Smith

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *50508*

Local Registrar's No. *231*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

W

(Write the word)

6. DATE OF BIRTH

July 24

(Month)

(Day)

1925

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rexburg

10. NAME OF FATHER

James R. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Pauline Weiland

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James R. Smith

(Address)

Shoshone, Ida

15.

Filed

78

1925

J. Lyons

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

(Month)

24

(Day)

1925

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 24* *1925* to *July 24* *1925*, that I last saw him alive on *July 24* *1925* and that death occurred on the date stated above, at *N.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.
Contributory (Secondary) *Placenta Marginalis*

(Duration) yrs. mos. ds.
(Signed) *B. R. Lyons* M. D.
19 (Address) *Rexburg, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Crematorium

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

453 210033-249
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC HEALTH

BUREAU OF VITAL STATISTICS

S

County of Madison

AUG 12 1925

City of Reynolds

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. 100 St. Registration District No. 100 State File No. 134081

Hospital Reynolds General

Primary Registration District No. 2178

Local Registrar's No. 1187

FULL NAME OF CHILD Mary Adeline Metzner

(Certificate of no value without full name of child)

Sex of Child Female

Twin
Triplet
or other?

} and

Number
in order
of birth

Legiti-
mate? Yes

Date of
birth July 10

(Month) (Day)

1925 (Year)

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

A. J. Metzner

RESIDENCE

Reynolds #3

COLOR

W

AGE AT LAST
BIRTHDAY 26
(Years)

BIRTHPLACE

Ida.

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Adeline Smith

RESIDENCE

Reynolds #3

COLOR

W

AGE AT LAST
BIRTHDAY 20
(Years)

BIRTHPLACE

Ida.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. B. Rigby

(Physician or midwife)

Address 78

Filed 78

1925

Registrar.

Registrar.

2 ME OF CHIPS

SRT

1950

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of *Madison*

City of *Parkburg*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

AUG 18 1925

BUREAU OF VITAL STATISTICS

District No. *100*
Union District No. *2178*
(No. *2178* St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *56509*

Local Registrar's No. *232*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED

M

W

Male

(Write the word)

6. DATE OF BIRTH

July

11

1925

(Month)

(Day)

(Year)

7. AGE

—

IF LESS than 1 day how many hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Baker

9. BIRTHPLACE

(State or Country)

Parkburg

10. NAME OF

Father

Alfred J. Metzger

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Adeline Smith

13. BIRTHPLACE

OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Metzger

(Address)

Parkburg

15.

8/8

1925

Myron G

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

11

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 11 1925 to July 11 1925

that I last saw him alive on *July 11 1925*

and that death occurred on the date stated above, at *—* M.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory (Secondary) *Infect. Placenta*

(Duration) yrs. mos. ds.

(Signed) *H. B. Rigby* M. D.

July 21 1925 (Address) *Parkburg Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parkburg

7/12 1925

20. UNDERTAKER

ADDRESS

Myron G

Parkburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

SEP 5 1925

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

S 34112

County of *Minidoka*

City of *Rupert*

No. *231-221034855* St.

Registration District No. *19*

State File No. *91*

Hospital

Primary Registration District No. *2015*

Local Registrar's No. *91*

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

girl

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

6 21

1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *1*

Number of child of this mother now living, including present birth *0*

FULL
NAME

FATHER

Le Roy Blacker

RESIDENCE

Rupert

COLOR

White

AGE AT LAST

BIRTHDAY

21

(Years)

BIRTHPLACE

Wys-

OCCUPATION

laborer

FULL
MAIDEN
NAME

MOTHER

Myrtle Hendricks

RESIDENCE

Rupert

COLOR

White

AGE AT LAST

BIRTHDAY

30

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Born alive* *Stillborn* at *9:00* M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

(Signature)

J. B. Kenagy

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

Aug. 4 1925

E. E. Elmer

Registrar.

Registrar.

1076

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth, stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of *Madison*

City of *Lemotm East*

No. *54120035 993* St.

AUG 17 1925

BUREAU OF VITAL

STATISTICS No.

CERTIFICATE OF BIRTH

134139

File No. _____

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD

Steel Born - Thurston

(Certificate of no value without full name of child.)

Sex of child *male*

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

July 30

1925

(To be answered only in event of plural births)

(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... *1*

Number of children of this mother now living, including present birth... *1*

FULL
NAME

FATHER

Engel R. Thurston

FULL
MAIDEN
NAME

MOTHER

Lorina Richardson

RESIDENCE

E. Lemotm

RESIDENCE

Same

COLOR

white

AGE AT LAST
BIRTHDAY

32
(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

29
(Years)

BIRTHPLACE

Ida

BIRTHPLACE

Wash.

OCCUPATION

Foreman - Construction

OCCUPATION

H. Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated.

Steel Born - at *5:30 a.* M.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

William H. H. H. H.

(Physician or midwife)

Give names added from a supplemental report.

Address

Lemotm

Filed *Aug 8* 1925

Ann E. Bruce

Registrar.

Registrar.

CERTIFICATE OF BIRTH

File No.

Registration No.

Registered No.

Registration District No.

Full Name of Child

(To be filled in by the registrar at the time of birth)

Sex of Child	Color of Child	Weight of Child	Length of Child	Head Circumference of Child	Birth Date	Birth Time	Birth Place
--------------	----------------	-----------------	-----------------	-----------------------------	------------	------------	-------------

Signature of Registrar	Signature of Mother	Signature of Father
------------------------	---------------------	---------------------

Color	Birth Date	Birth Time	Birth Place	Occupation
-------	------------	------------	-------------	------------

CERTIFICATE OF ATTENDANCE

I hereby certify that the child of this child, who was born on the date above stated, is now attending school at the following school:

School Name: _____

School Address: _____

Teacher's Name: _____

Signature of Registrar: _____

Signature of Mother: _____

Signature of Father: _____

RECEIVED BY THE STATE DEPARTMENT OF HEALTH, NEW YORK CITY, MAY 10, 1910.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 BEGAIN RESEMBLED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Lewiston

City of Lewiston
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

AUG 17 1925

Registration District No. 95-96

PHYSICIAN'S SIGNATURE District No. 1009

(No. St.)

St. El Born Knutson

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

State File No. 56531

Local Registrar's No. 1846

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single

(Write the word)

6. DATE OF BIRTH

July 20 1925
 (Month) (Day) (Year)

7. AGE

St. El Born
 IF LESS than 1 day how many hrs. or min.?
nil

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Lewiston Ida

10. NAME OF FATHER

E. A. Knutson

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Leona Beckhard

13. BIRTHPLACE OF MOTHER

(State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. A. Knutson
 (Address)

15.

Filed July 20 1925 W. E. Stoddard
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 20 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19. that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

St. El Born. Calcification
flaccida.
 (Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
 (Signed) W. E. Stoddard M. D.
720 1925 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. days. State yrs. mos. ds.
 Where was disease contracted
 if not at place of death?
 Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Normal Hill Cemetery 7/20 1925

20. UNDERTAKER

ADDRESS

Vassar Undertaking Co Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

819 125 035-897 .
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nezperce

City of Lewiston Idaho

No. _____ St. _____

Hospital White

FULL NAME OF CHILD

RECEIVED

AUG 17 1925

Registration District No. 96
BUREAU OF VITAL
STATISTICS

Primary Registration District No. 1009

File No.

134143

Registered No.

Full Name of Child Harris

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>July, 25</u> 192 <u>5</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth None Number of child of this mother now living, including present birth None

FATHER
FULL NAME Harry E. Harris
RESIDENCE Lewiston Idaho
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Moscow
OCCUPATION Electrician

MOTHER
FULL MAIDEN NAME Mahek G. Highy
RESIDENCE Lewiston Idaho
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Spokey Mn
OCCUPATION House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born on the date above stated. 6:20 P. M.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Edgar L. White

(Physician or midwife)

Give names added from a supplemental report.

Address

Lewiston, Idaho

Filed Aug 8 1925

Marion E. Bruce

Registrar.

Registrar.

2

1000

1000

1000

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *My Perce*
City of *Leoviston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stithorn Harris

RECEIVED
AUG 14 1925
BUREAU OF VITAL STATISTICS
Registration District No. *96*
Registration District No. *1009*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *50535*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED
Single
(Write the word.)

6. DATE OF BIRTH

July 25 1925
(Month) (Day) (Year)

7. AGE

0 Yrs. *7* Mos. *2* Wks. *sterile gestation*
IF LESS than 1 day how many *0* hrs. or *0* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Leoviston, White's Brother*

10. NAME OF FATHER

Guy E Harris

11. BIRTHPLACE OF FATHER

(State or Country) *Leoviston*

12. MAIDEN NAME OF MOTHER

Mabel Hgley

13. BIRTHPLACE OF MOTHER

(State or Country) *Wash'n*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Guy Harris
(Address) *425 15th St. Leoviston*

15.

Filed *Aug 8* 1925 *Susan E Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 25 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...

that I last saw him alive on 19...

and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

*premature birth
7 month pregnancy
still born*

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Not Known*

(Duration) Yrs. mos. ds.

(Signed) *Edgar P. White* M. D.

8-11 1925 (Address) *Leoviston Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leoviston Ida

7-27-1925

20. UNDERTAKER

ADDRESS

Vassar W Co

Leoviston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

SEP 4 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Latah

City of Leticia R.D. 1

No. 281 214041 349

St. Registration District No. 77

State File No. 134190

Hospital

Primary Registration District No. 2176

Local Registrar's No. 16

FULL NAME OF CHILD Still born

(Certificate of no value without full name of child)

Sex of Child Y

Twin
Triplet
or other

and

Number
in order
of birth 1

Legiti-
mate? +

Date of
birth Aug. 14 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Alma Ray Shaw

RESIDENCE

Leticia, R.D. 1

COLOR

White

AGE AT LAST
BIRTHDAY 33

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Gloria Turner

RESIDENCE

Do.

COLOR

W

AGE AT LAST
BIRTHDAY 24

(Years)

BIRTHPLACE

Colorado

OCCUPATION

H.W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 900 1 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. R. Padue, M.D.

(Physician or midwife)

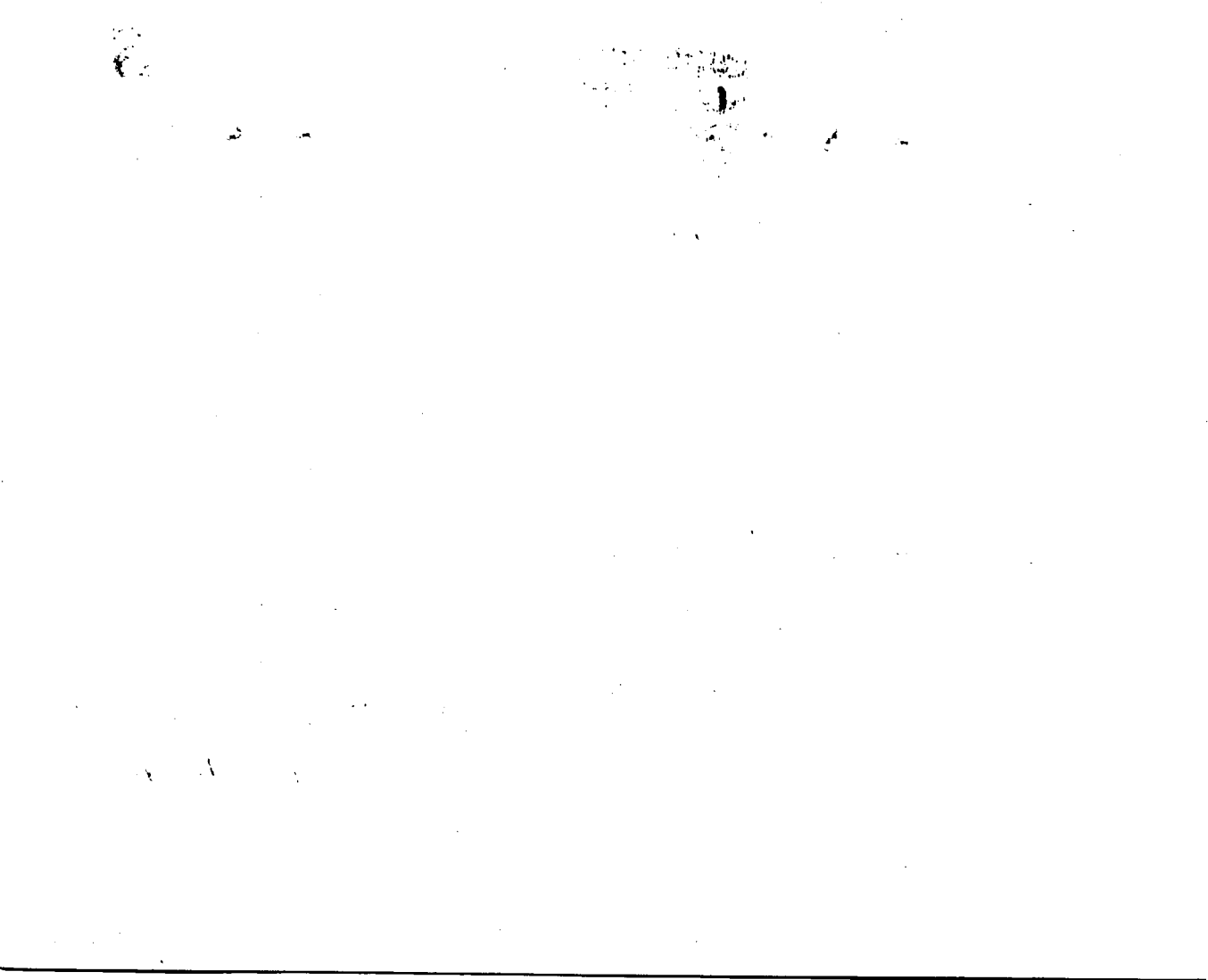
Address Driggs, Idaho.

Filed 8-26- 1925

Martha Marker

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19

RECEIVED

SEP 4 1925

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of IdahoCity of Idaho Falls R.D. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(No.

District No. 77Registration District No. 9176

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 50548Registered No. Two

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 8-26- 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 25
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

1925

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clawson, Idaho.8-15-1925

20. UNDERTAKER

ADDRESS

FEB 18 1966

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

521-11th W.

STATE OF IDAHO

S

County of

Twin Falls

City of

Twin Falls

No.

521-4th St.

Hospital

386-223 642-296

RECEIVED

SEP 2 1925

BUREAU OF VITAL
STATISTICSDEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

134233

Register No.

37

State File No.

Primary Registration District No.

1085

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

J

Twin
Triplet
or other?} and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

8-23

1925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

10

Number of child of this mother now living, including present birth

9

FULL
NAME

FATHER

Herman P Thomas

RESIDENCE

Twin Falls

COLOR

W

AGE AT LAST
BIRTHDAY

45

(Years)

BIRTHPLACE

Mo.

OCCUPATION

Carpenter

FULL
MAIDEN
NAME

MOTHER

Lindy M. Brothers

RESIDENCE

Twin Falls

COLOR

W

AGE AT LAST
BIRTHDAY

43

(Years)

BIRTHPLACE

Kans.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ☒ Stillborn ☐ at 3-20 P M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

John F. Coughlin

(Physician or midwife)

Address

Twin Falls, Ida.

Filed

Sept 1, 1925

Registrar.

Registrar.

8

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Twin Falls
City of Twin Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Thomas

CERTIFICATE OF DEATH

Registration District No. 37

Registration District No. 1085
4th St. St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 50566

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single
(Write the word)

6. DATE OF BIRTH

Aug. 23 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
_____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF

Father Herman E. Thomas

11. BIRTHPLACE

OF FATHER Mo.

12. MAIDEN NAME

OF MOTHER Lindy M. Brothers

13. BIRTHPLACE

OF MOTHER Kans

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Birth certificate

(Address) _____

15.

Filed Sept 1 1925 John Houghlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 23 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____ to _____ 19____,

that I last saw him alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John J. Houghlin M. D.

8/23/1925 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

8/24 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

S

OCT 3 1925

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

134279

County of Ada

City of Boise

No. 255 111 901-863

St. Registration District No. 2

State File No.

Hospital St. Alphonsus

Primary Registration District No. 1004

Local Registrar's No. 309

FULL NAME OF CHILD

Max Snellgrove Jr.

(Certificate of no value without full name of child)

Sex of
Child

M

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date
birth

July 11

1925

(Month) (Day)

(Year)

What bactericidal solution was used in eyes?

Agnes 3 190 Sol

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

0

FULL
NAME

FATHER

Max Snellgrove

RESIDENCE

Boise Ida

COLOR

White

AGE AT LAST
BIRTHDAY

19
(Years)

BIRTHPLACE

Arkansas

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Arvinte Haleson

RESIDENCE

Boise Ida

COLOR

White

AGE AT LAST
BIRTHDAY

21
(Years)

BIRTHPLACE

Neosho Mo

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 10 30 A M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

A B Brook

(Physician or midwife)

Address

Boise Idaho

Filed

Oct 30 1925

Registrar.

Registrar.

2

1. The first part of the document is a list of the names of the persons who have been named in the document. The names are listed in alphabetical order.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
AUG 4 1925

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hosp.)

File No. 50174
Registered No. 171

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Max Snellgrove Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH July 11 1925
(Month) (Day) (Year)

7. AGE Stillborn
Yrs. Mos. ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Boise Ida
(State or Country)

10. NAME OF FATHER Max Snellgrove

11. BIRTHPLACE OF FATHER Ark.
(State or Country)

12. MAIDEN NAME OF MOTHER Annette Hobson

13. BIRTHPLACE OF MOTHER Ida
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Max Snellgrove
(Address) Boise

15. Filed 7-28-25
Local Registrar R. J. Pratt

MEDICAL CERTIFICATE OF DEATH

189-b

16. DATE OF DEATH July 11 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1925 to 19
that I last saw him alive on 19

and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. J. Bouch M. D.
19 (Address) 315 8th Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Boise Valley Ada Ida

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL July 12 1925

20. UNDERTAKER Schubert & Hildebrandt ADDRESS Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma* *Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train*—accident; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County Canyon
City of Lawney
No. 366-220-001-556 St.

RECEIVED
OCT 13 1925
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH **134326**
Reg. No. 88 State File No. 150

Hospital _____ Primary Registration District No. 260 Local Registrar's No. 150

FULL NAME OF CHILD Lerena Marie Howe
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u>	and {	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Sept-20-1925</u> (Month) (Day) (Year)
----------------------------	----------------------------------	-------	-----------------------------------	------------------------	---

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? Eugyrol

Number of child of this mother, including present birth <u>7</u>		Number of child of this mother now living, including present birth <u>6</u>	
FULL NAME <u>L. E. Howe</u>	FATHER	FULL MAIDEN NAME <u>May McRobold</u>	MOTHER
RESIDENCE <u>Lawney, Idaho</u>		RESIDENCE <u>Lawney, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>46</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>England</u>		BIRTHPLACE <u>Smithfield, Utah</u>	
OCCUPATION		OCCUPATION <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 4:55 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) [Signature]

(Physician or midwife)

Address Lawney, Idaho

Filed Oct. 10 1925 Mary C. Coffin

Registrar.

43/4

Registrar.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the efficient operation of any business or organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the role of technology in modern business operations. It highlights how advancements in computer science and data processing have revolutionized the way companies manage their resources and interact with customers. This section provides a detailed overview of the various tools and techniques used in the field of business technology.

3. The third part of the document addresses the challenges faced by businesses in the current market environment. It discusses the impact of global economic trends, such as inflation and supply chain disruptions, on business performance. This section also offers strategies for overcoming these challenges and maintaining a competitive edge in the marketplace.

4. The fourth part of the document provides a comprehensive overview of the various factors that influence business success. It examines the role of human resources, marketing, and financial management in achieving long-term growth and profitability. This section also discusses the importance of innovation and research and development in driving business progress.

5. The fifth part of the document concludes with a summary of the key findings and recommendations. It emphasizes the need for continuous improvement and adaptation to changing market conditions. This section also provides a final overview of the document's content and a call to action for the reader to implement the suggested strategies.

6. The sixth part of the document contains a list of references and a bibliography. It includes a detailed list of the sources used in the research and a list of the works cited in the document. This section is essential for providing context and credibility to the information presented in the document.

7. The seventh part of the document contains a list of appendices and a glossary. It includes a list of the additional materials included in the document and a list of the terms and definitions used throughout the text. This section is essential for providing a complete and accurate representation of the document's content.

8. The eighth part of the document contains a list of footnotes and a list of references. It includes a list of the additional information provided in the document and a list of the works cited in the document. This section is essential for providing a complete and accurate representation of the document's content.

9. The ninth part of the document contains a list of footnotes and a list of references. It includes a list of the additional information provided in the document and a list of the works cited in the document. This section is essential for providing a complete and accurate representation of the document's content.

10. The tenth part of the document contains a list of footnotes and a list of references. It includes a list of the additional information provided in the document and a list of the works cited in the document. This section is essential for providing a complete and accurate representation of the document's content.

State of Idaho
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, OCT 14 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

RECEIVED
OCT 22 1925
BUREAU OF VITAL
STATISTICS

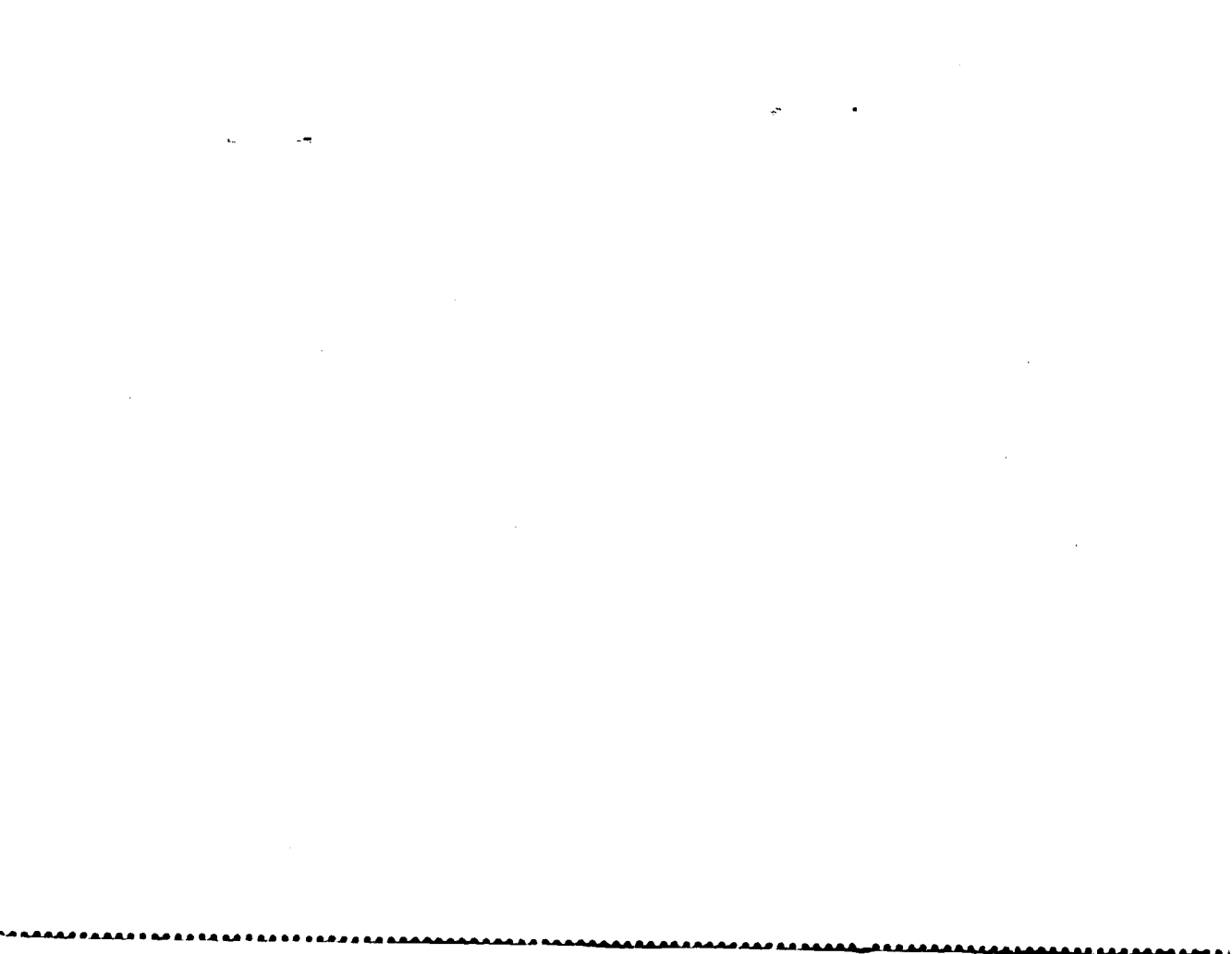
Place of Birth { owner
ST. FILE NO. 134326
DATE OF BIRTH Sept 20 1925
COUNTY Blaine SEX OF CHILD girl
FATHER James Lowe MOTHER Mae Newbold
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Lerena Merle Lowe

Mae Newbold

Signature of Father or Mother.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bannock*
City of *Pawnee*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

OCT 13 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *83*Registration District No. *2160*

St.)

*Baby Lowe*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **50612**Registered No. *28*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Sept - 20 - 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pawnee, Idaho

10. NAME OF FATHER

James E. Lowe

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

May Newbold

13. BIRTHPLACE OF MOTHER

(State or Country)

Smithfield, Wb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James E. Lowe

(Address)

15.

Filed *Oct. - 10 - 1925* *Mary C. Coffin*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept - 20 - 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to *19*
that I last saw h. — alive on *19*
and that death occurred on the date stated above, at *19* M.

The CAUSE OF DEATH* was as follows:

Still Birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)*Not known*

(Duration) yrs. mos. ds.

(Signed)

H. H. Hartigan

M. D.

9-31-1925 (Address) *Pawnee, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of BannockCity of DawneyNo. 219121003266 St. Reg.RECEIVED
OCT 18 1925
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

No. 83 State File No. 134331Hospital _____ Primary Registration District No. 2160 Local Registrar's No. 154

FULL NAME OF CHILD

Ray H. Borfus

Certificate of no value without full name of child

Sex of Child <u>male</u>	Twin Triplet or other? <u>no</u>	and {	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Sept-21-1925</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bactericidal solution was used in eyes? 7thNumber of child of this mother, including present birth 4th Number of child of this mother now living, including present birth 4

FULL NAME <u>John Borfus</u>	FATHER
RESIDENCE <u>Dawney, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>41</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>farmer</u>	

FULL MAIDEN NAME <u>May Bowman</u>	MOTHER
RESIDENCE <u>Dawney, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Richmond, Idaho</u>	
OCCUPATION <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at 6:15 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. H. Borfus, M.D.
Physician
(Physician or midwife)

Address

Dawney, Idaho

Filed

Oct 10, 1925

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

02 947 1112

"ADULTS."

State of Idaho

DEPARTMENT OF PUBLIC WELFARE

OCT 14 1925

Boise, Idaho,

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

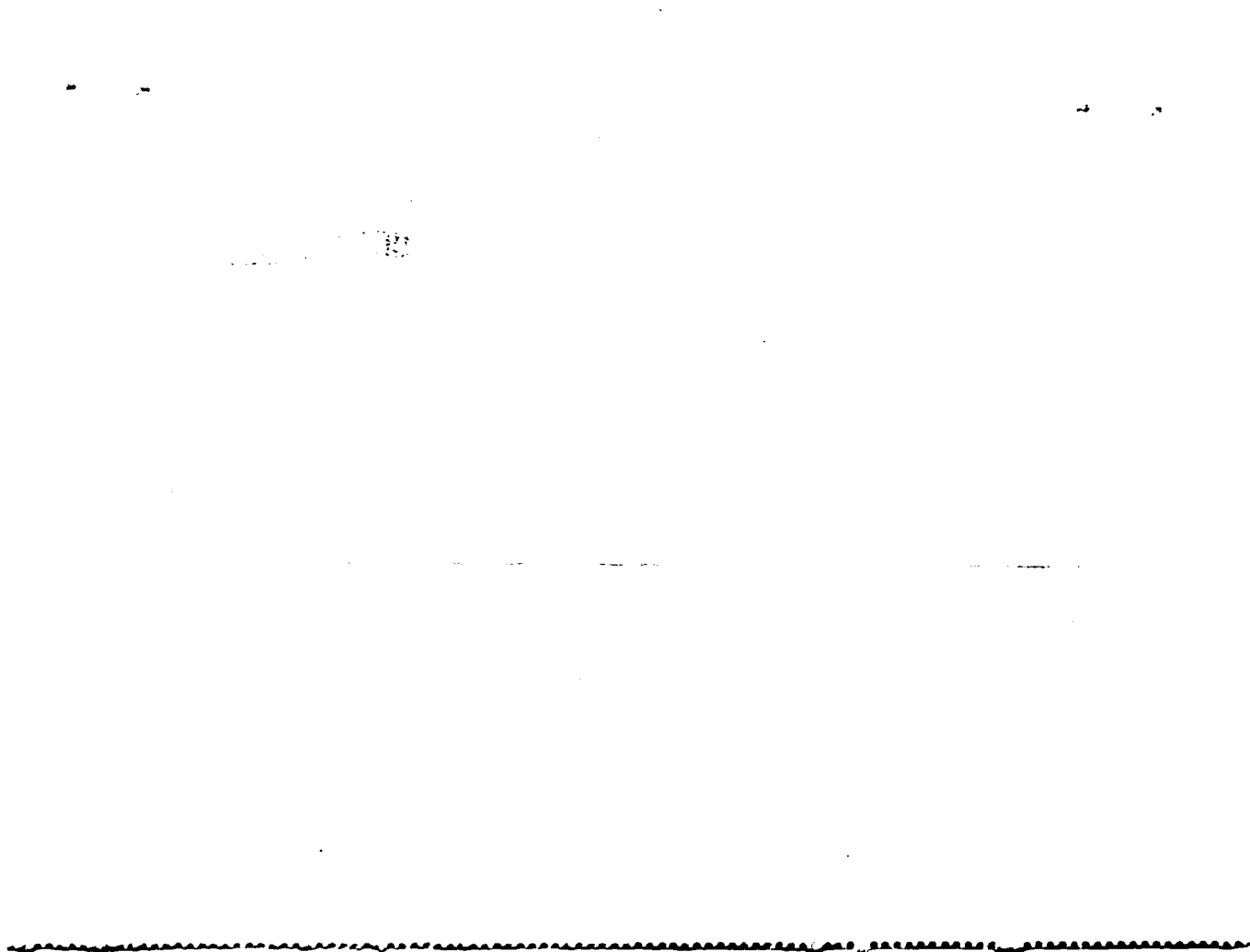
RECEIVED
OCT 22 1925
BUREAU OF VITAL
STATISTICS
Place

of Birth	CITY	<i>Dawson</i>	FILE NO.	134331
	ST.	<i>Idaho</i>	DATE OF BIRTH	<i>Sept 21-1925</i>
	COUNTY	<i>Bannock</i>	SEX OF CHILD	<i>Boy</i>
	FATHER	<i>John A. Barfuss</i>	MOTHER	<i>May Bowman</i> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Voy. E. Barfuss

John A. Barfuss
Signature of Father or Mother.



1. PLACE OF DEATH

County of Bannock
 City of Pawnee

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
OCT 10 1925
BUREAU OF VITAL STATISTICS
 Registration District No. 2160
 (N. STATISTICS)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. **50611**Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Sept - 21 - 1925
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pawnee, Idaho

10. NAME OF FATHER

John Barfus

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Richmond, Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Barfus

(Address)

15.

Filed Oct - 10 - 1925 Mary C. Coffin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept - 21 - 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Six months gestation.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Acute nephritis in mother

(Duration) yrs. mos. ds.

(Signed) H. Hartwig M. D.9-21-1925 (Address) Pawnee, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of Bear Lake RECEIVED DEPARTMENT OF PUBLIC WELFARE
City of Paris SEP 11 1925 BUREAU OF VITAL STATISTICS
No. 466-11004-449 St. STATISTICS District No. 53 State File No. 134396
Hospital _____ Primary Registration District No. _____ Local Registrar's No. 299

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? Yes Date of birth Aug 11 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER

FULL NAME Charles Otto Moore

RESIDENCE Paris Idaho

COLOR White AGE AT LAST BIRTHDAY 38
(Years)

BIRTHPLACE Missouri

OCCUPATION Physician

MOTHER

FULL MAIDEN NAME Josephine G. Durkee

RESIDENCE Paris Idaho

COLOR White AGE AT LAST BIRTHDAY 33
(Years)

BIRTHPLACE Utah

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn { Sex Male } at 2.30 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

C. O. Moore M.D.

(Physician or midwife)

Address Paris Idaho

Filed 9-1 1925 Mrs. J. S. Skinner

Registrar.

Registrar.

NO BC

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

553-121-206-769
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham
City of Blackfoot

RECEIVED

OCT 7 1925

CERTIFICATE OF BIRTH 134456

No. _____ St. BUREAU OF VITAL STATISTICS District No. 121 State File No. _____
Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 289

FULL NAME OF CHILD Rigal Louie Nelson

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Sept. 21</u> 19 <u>25</u> (Month) (Day) (Year)
--------------------------	--	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME Carl W. Nelson
RESIDENCE Blackfoot, Idaho # I
COLOR White AGE AT LAST BIRTHDAY 47 (Years)
BIRTHPLACE Nebraska
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Arvilla Porter
RESIDENCE Blackfoot, Idaho # I
COLOR White AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Penn.
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7.30.A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Blackfoot, Idaho

Filed Oct. 1-1925

Registrar.

Registrar.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **50639**
Registered No. **101**

1. PLACE OF DEATH

County of BurghamCity of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

1925

Bureau of Vital Statistics

Registration District No. 121Registration District No. 2194(No. R F H 1)

St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)21
(Day)1925
(Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day
how many ✓ hrs.
or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Burgham Idaho

10. NAME OF FATHER

Carl W Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Aurora Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl W Nelson

(Address)

Blackfoot, Idaho

15.

Filed

Sept. 21 1925Mr. Walter E. Porter

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept
(Month)21
(Day)1925
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 21 1925, to Sept 21 1925that I last saw him alive on Sept 21 1925and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Still born(Duration) — Yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.

(Signed)

H. W. Mitchell

M. D.

9/21 1925 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funeral HomeSept. 21 1925

20. UNDERTAKER

ADDRESS

E. J. ParkBlackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

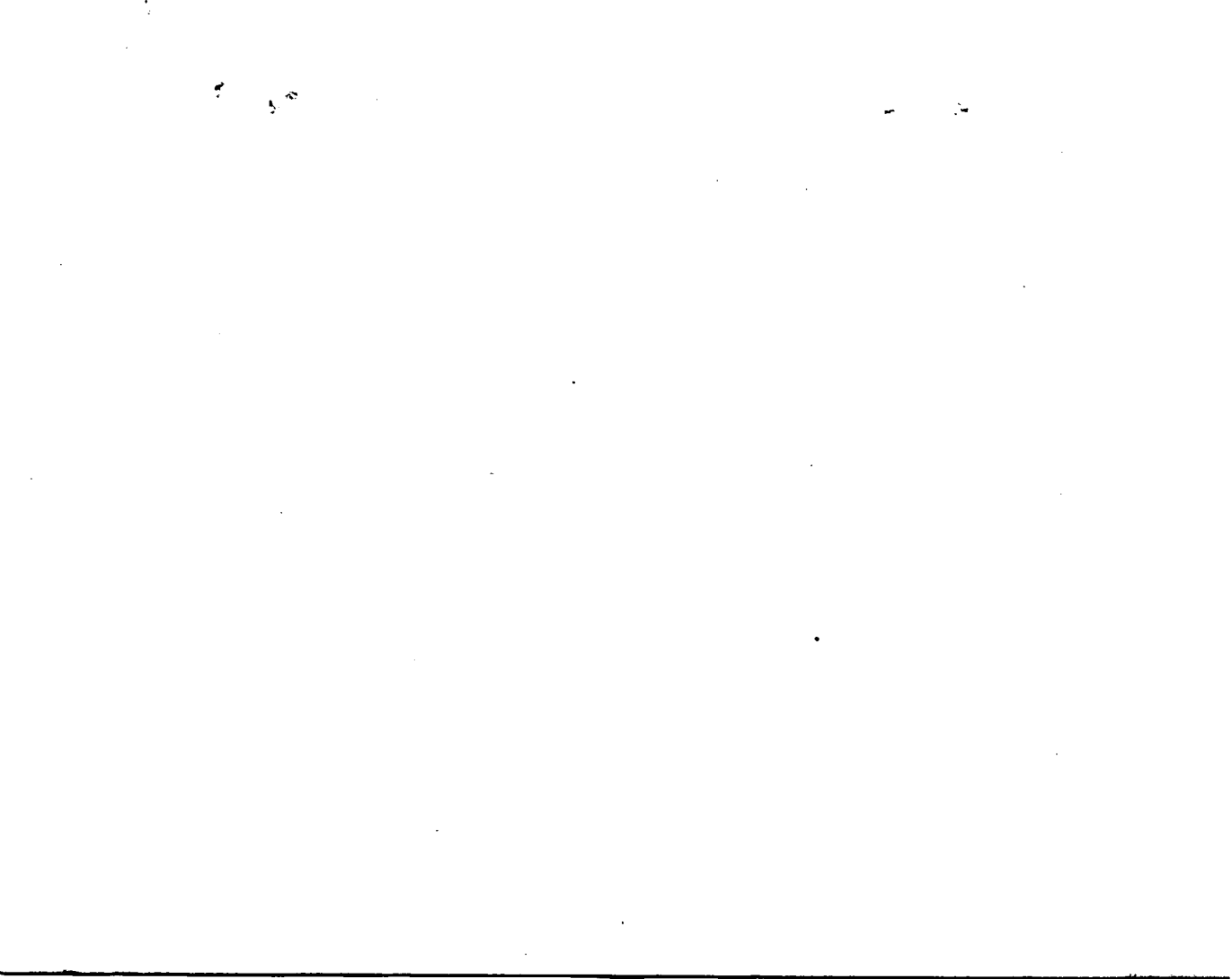
STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

132-227-007-132		OCT 5 1925		STATE OF IDAHO	
PLACE OF BIRTH		BUREAU OF VITAL STATISTICS		DEPARTMENT OF PUBLIC WELFARE	
County of Blaine		BUREAU OF VITAL STATISTICS		134472	
City of Austin (Fair Park)		Registration District No. 57		File No.	
No.		St.		Hospital	
Primary Registration District No. 2075		Registered No. 71			
FULL NAME OF CHILD Louise Thelma Atkinson					
(Certificate of no value without full name of child.)					
Sex of Child	Twin Triplet or other?	and	Number in order of birth	Legitimate	Date of birth
Female				mo	8 27 1925
(To be answered only in event of plural births)					
What bactericidal solution was used in eyes?					
Number of child of this mother, including present birth. 0					
Number of child of this mother now living, including present birth. 0					
FULL NAME FATHER			FULL MAIDEN NAME MOTHER		
RESIDENCE			RESIDENCE		
COLOR			COLOR		
AGE AT LAST BIRTHDAY (Years)			AGE AT LAST BIRTHDAY (Years)		
BIRTHPLACE			BIRTHPLACE		
OCCUPATION			OCCUPATION		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE					
I hereby certify that I attended the birth of this child, who was, at 10 15 a. M.					
on the date above stated.					
(Born alive or stillborn)					
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.					
(Signature) E. W. Fox					
Physician (Physician or midwife)					
Address Haledale					
Filed 10-2 1925 Robert H. Wagner					
Registrar.					



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Expect statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

1. PLACE OF DEATH

County of *Blaine*

City of *Larey*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

OCT 3

CERTIFICATE OF DEATH

Registration District No. *57*

Primary Registration District No. *2025*

(No. *Twila Louise Atkinson* St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *50657*

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female *white* *Single*
(Write the word)

6. DATE OF BIRTH

8 *27* *1925*
(Month) (Day) (Year)

7. AGE

Still born
IF LESS than 1 day how many
hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Larey, Idaho*

10. NAME OF

Father *not known*

11. BIRTHPLACE

OF FATHER
(State or Country) *—*

12. MAIDEN NAME

OF MOTHER *Louise Shulman Atkinson*

13. BIRTHPLACE

OF MOTHER
(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louise Atkinson
(Address) *Larey, Idaho*

15.

Filed *10 - 2* 19 *25* *C. K. Wright*
Local Registrar

MEDICAL CERTIFICATE OF DEATH *1896*

16. DATE OF DEATH

8 *27* *1925*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born Atelecasis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. W. Fox M. D.

8/29/25 (Address) *Larey, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Larey, Idaho *8/29* *1925*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia;** **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

271-222-007-231

PLACE OF BIRTH

RECEIVED

OCT 5 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Blaine

City of Carey

No. St.

Hospital

Registration District No. 57

File No. 134474

Primary Registration District No. 2075

Registered No. 702

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child Female	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? yes	Date of birth... 8 22 5 (Month) (Day) (Year)
------------------------	---	-----	--------------------------------	-------------------------	--

What bacterioidal solution was used in eyes?

Number of child of this mother, including present birth... 0 Number of child of this mother now living, including present birth... 0

FATHER		MOTHER	
FULL NAME Alfred Wm Sparks	FULL MAIDEN NAME Conklate Stanford		
RESIDENCE Carey, Idaho	RESIDENCE Carey, Idaho		
COLOR White	COLOR White	AGE AT LAST BIRTHDAY... 27 (Years)	AGE AT LAST BIRTHDAY... 23 (Years)
BIRTHPLACE Carey, Idaho	BIRTHPLACE Carey, Idaho		
OCCUPATION Farmer	OCCUPATION Housewife		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

(Born alive or stillborn) 1302 M.

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Give names added from a supplemental report.

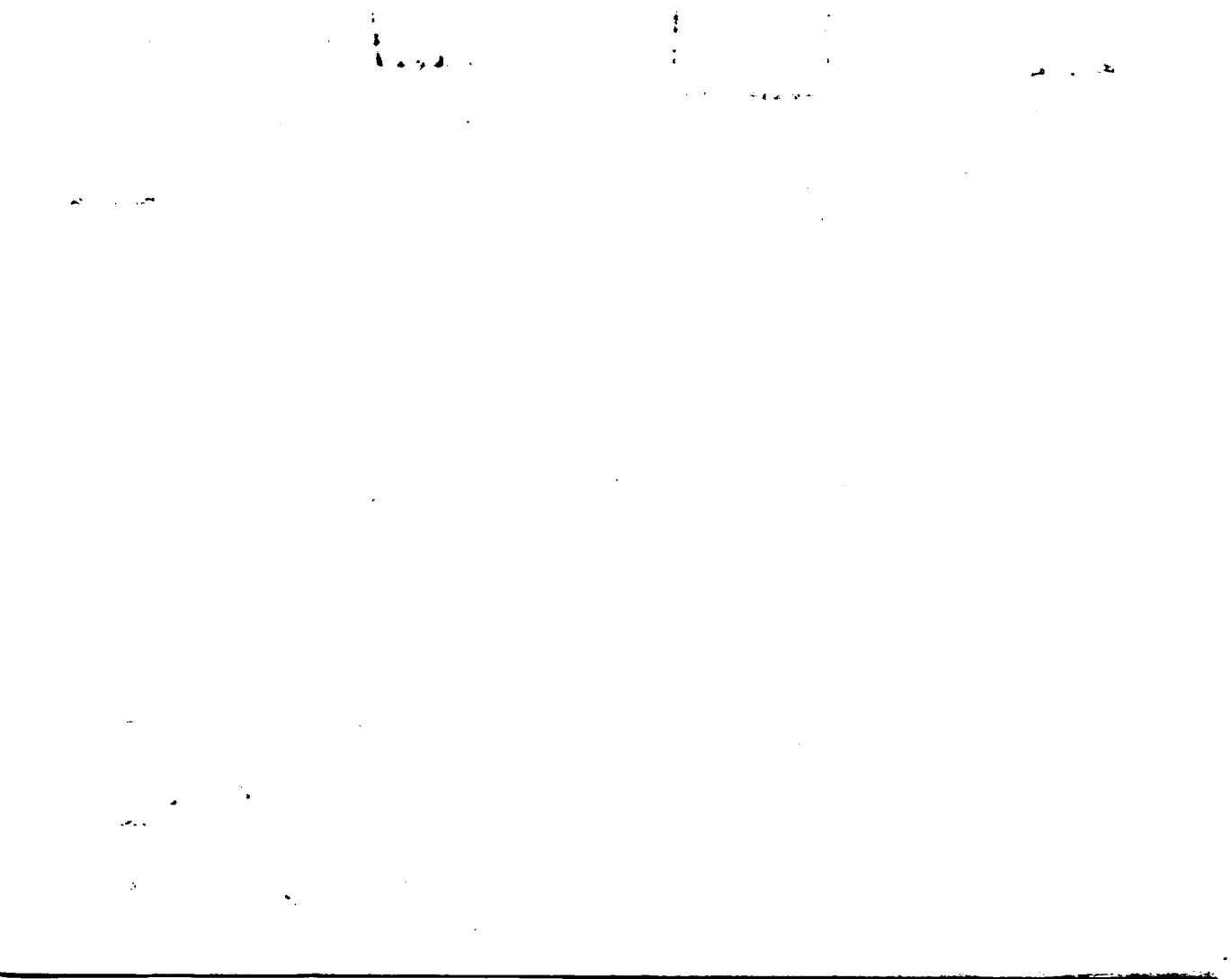
Address

Filed

1925

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH
County of Blaine
City of Larey
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
BUREAU OF VITAL STATISTICS
Registration District No. 57
Registration District No. 2025
(STATISTICAL ST.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 50656
Local Registrar's No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

(Infant) Sparke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH 8 22 1925
(Month) (Day) (Year)

7. AGE Still born IF LESS than 1 day how many 8 hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Larey, Idaho

10. NAME OF FATHER Alfred Wm Sparke

11. BIRTHPLACE OF FATHER (State or Country) Larey, Idaho

12. MAIDEN NAME OF MOTHER Elon Vilate Stanford

13. BIRTHPLACE OF MOTHER (State or Country) Larey, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred Sparke
(Address) Larey, Idaho

15. Filed 10-2 19 25 P. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 - 22 19 25
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19,
that I last saw h. alive on 19,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Stillborn - chlamydia with injury at birth
(Duration) yrs. mos. ds.

Contributory (Secondary) _____
(Duration) yrs. mos. ds.
(Signed) E. W. Fox M. D.
2249 25 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days, State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Larey, Idaho DATE OF BURIAL 8 24 19 25

20. UNDERTAKER P. D. Harris ADDRESS Hailey

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

962-111-009-238

Bonner

County of

City of Sandpoint

No. State File No. District No. 76 State File No.

Hospital Primary Registration District No. 2155 Local Registrar's No.

FULL NAME OF CHILD still born

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? } and { Number in order of birth Legitimate? yes Date of birth 8/11/25 192 (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
Stephen Charles Roberts	Sandpoint	Elise Schlunegger	Sandpoint
COLOR white	AGE AT LAST BIRTHDAY 37 (Years)	COLOR White	AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Switzerland		BIRTHPLACE Switzerland	
OCCUPATION farmer		OCCUPATION hsw.	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at { Sandpoint } P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. R. Wallentin

M.D.

(Physician or midwife)

Address Sandpoint

Filed Sept. 3, 1925

Registrar.

Viola Allen
Deputy Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

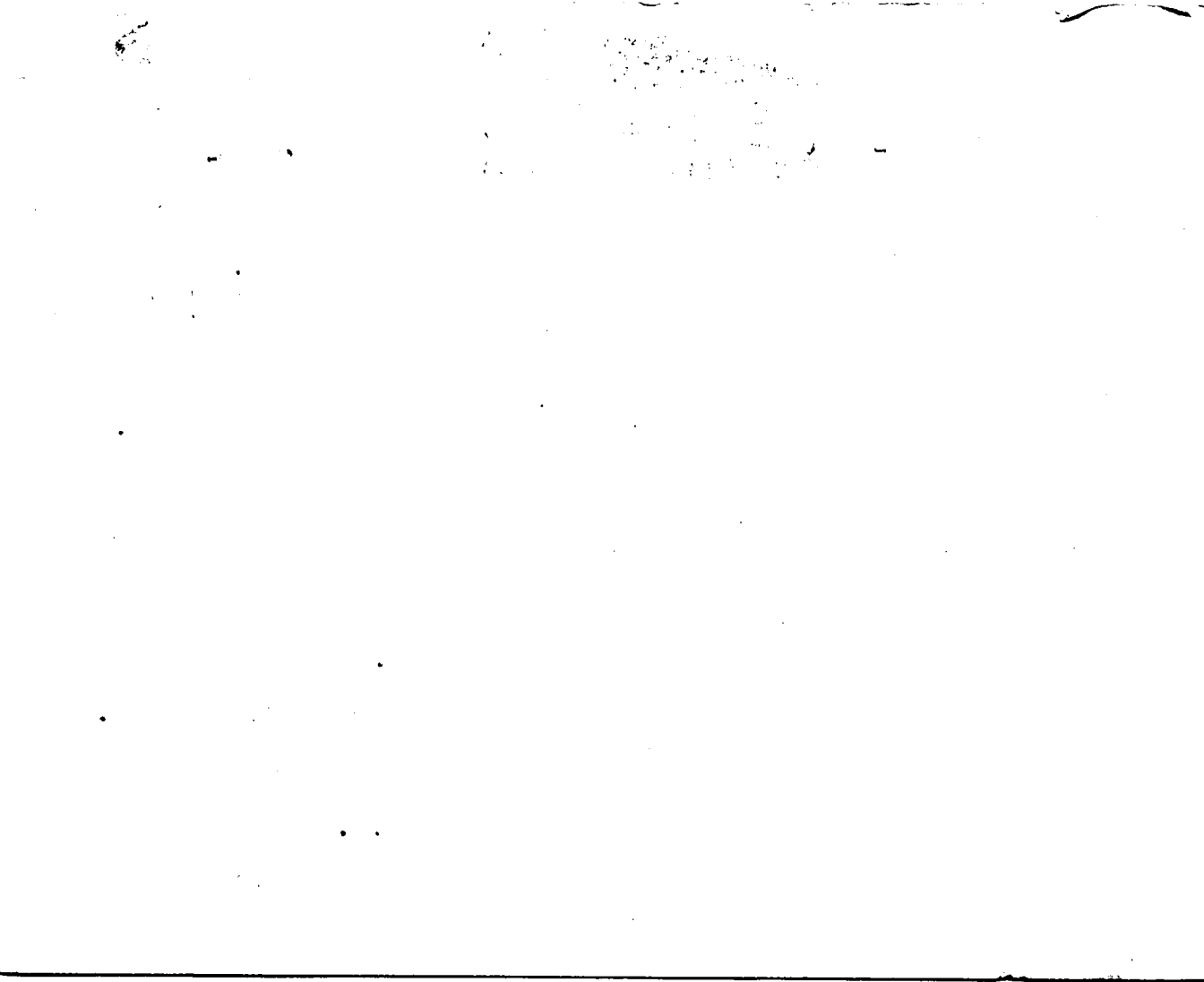
RECEIVED

SEP 10 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
134502



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

Bonner
County of Sandpoint
City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 8 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 76
Registration District No. 2155
(No.) St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 50663
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH 8/11/25
(Month) (Day) (Year)

7. AGE stillborn
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Stephen Charles Roberts

11. BIRTHPLACE OF FATHER Switzerland
(State or Country)

12. MAIDEN NAME OF MOTHER Elise Schlunegger

13. BIRTHPLACE OF MOTHER Switzerland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stephen Roberts
(Address) Sandpoint Idaho

15. Filed 8-11-1925 Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8/11/25
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: stillborn, cause of stillbirth unknown.

(Duration) Yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) H. R. Wallentin M. D. 8/12/1925 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days. Where was disease contracted if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sandpoint (rural) DATE OF BURIAL Aug. 11, 1925
20. UNDERTAKER father ADDRESS Sandpoint (rural)

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of **Franklin**

City of **Clifton**

No.

Hospital

FULL NAME OF CHILD.....

Sex of
Child **Male**

~~Twin~~
~~Twins~~
~~or others?~~

and { Number
in order
of birth

1

Legiti-
mate?

Yes

Date of
birth

August 27, 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth.....

5

Number of child of this mother now living, including present birth.....

1

FULL
NAME

FATHER

Marion Howell

RESIDENCE

Clifton, Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

28

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Elisie Sant

RESIDENCE

Clifton, Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

29

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { **Stillborn** } at **9:30 A.** M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Physician

(Physician or midwife)

Preston, Idaho

Address

Filed **Sept. 3, 1925**

Registrar.

Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

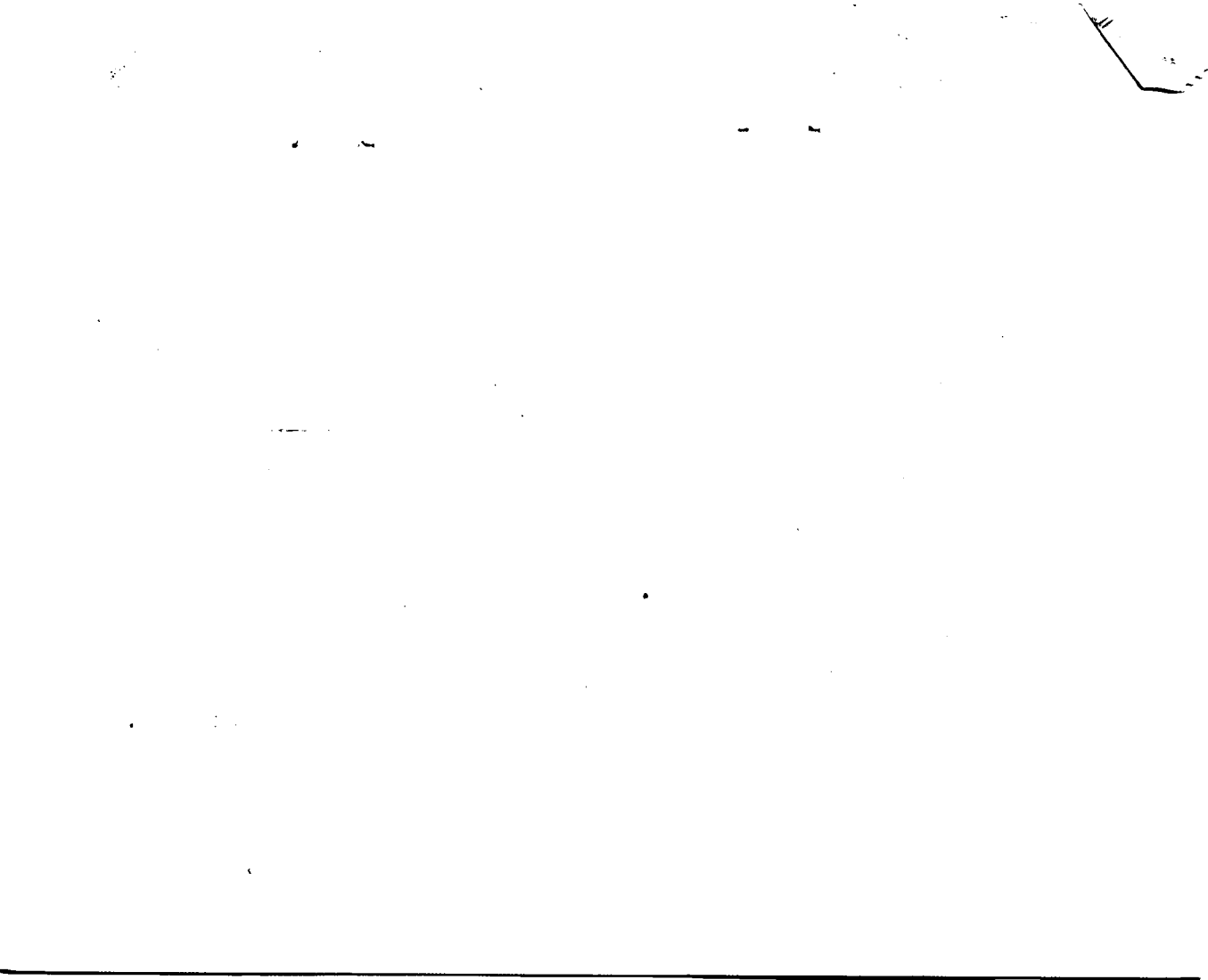
CERTIFICATE OF BIRTH

RECEIVED
SEP 12 1925
BUREAU OF VITAL
STATISTICS

St. Registration District No. **27**

State File No. **134635**

Primary Registration District No. **2119** Local Registrar's No. **180**



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH
County of **Franklin**
City of **Clifton**

If death occurs away from
usual residence, give facts
called for under special in-
formation.

RECEIVED MEDICAL CERTIFICATE OF DEATH
SEP 11 1925
Registration District No. **27**
BUREAU OF VITAL STATISTICS District No. **2119**
(No. **2119** St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. **50732**
Local Registrar's No. **46**
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME **Infant (Howell)**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Single
(Write the word)

6. DATE OF BIRTH
August 27, 1925
(Month) (Day) (Year)

7. AGE
0 Yrs. **0** Mos. **0** ds.
IF LESS than 1
day how many
0 hrs. or
0 min.?

8. OCCUPATION
(a) Trade, profession or
particular kind of work **Stillborn**
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE
(State or Country) **Clifton**

10. NAME OF
Father **Marion Howell**

11. BIRTHPLACE
OF FATHER **Idaho**
(State or Country)

12. MAIDEN NAME
OF MOTHER **Elisie Sant**

13. BIRTHPLACE
OF MOTHER **Idaho**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **A. R. Cutler Jr. Per V. C.**
(Address) **Preston, Idaho**

15. Filed **Sept. 5- 1925** **A. R. Cutler Jr.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
..... 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

not known Stillborn
(Duration) yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) **A. R. Cutler Jr.** M. D.
Preston, Idaho
19..... (Address)

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)
At place In the
of death yrs. mos. days, State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL
Clifton Cemetery DATE OF BURIAL
8-28- 19.....

20. UNDERTAKER
ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

646-213-018-112
PLACE OF BIRTH

PLACE OF BIRTH

2
RECEIVED
SEP 21 1925
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO

S

134676

City of Elk River-

No......

St.

Registration District No. 97

..State File No.

Hospital Elk River

Primary Registration District No. _____

Local Registrar's No.

FULL NAME OF CHILD

Unnamed

(Certificate of no value without full name of child)

Sex of Child female

**Twin
Triplet
or other?**
(To be

and { Number
in order
of birth
only in event of pl

Legitimate? yes

Date of birth.....Aug.....13.....1925.
(Month) (Day) (Year)

What bactericidal solution was used in eyes?.....none

Number of child of this mother, including present birth_____

Number of child of this mother now living, including present birth.....

FULL NAME	FATHER Norman E. O'Donnell
--------------	-------------------------------

FULL MAIDEN NAME	MOTHER Mary Jassman
------------------------	------------------------

RESIDENCE Elk River

RESIDENCE Elk River

COLOR White AGE AT LAST BIRTHDAY 27 (Years)

COLOR White AGE AT LAST BIRTHDAY 29
(Years)

BIRTHPLACE U. S.

BIRTHPLACE U. S.

OCCUPATION Post-master

OCCUPATION House-wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or ~~XXXXXXXXXX~~

Give names added from a supplemental report.
 _____, 192_____

Address Elk River, Idaho

Filed Sept. 10 1923 Mildred Hamby
Registrar

Registrar

[illegible]

(The copies added from a supplemental report shows other evidence of the fact that there is one that neither Oswald nor Lee would make the same statement as given by Oswald; then the latter would have no reason why he was not talking to Oswald.)

Revised

DATE OF LAST BIRTHDAY

RESIDENCE
FATHER
NAME
FULL

Number of child of this mother, including this child

[illegible][illegible]

10-10-68

111627

2

U.S. DEPARTMENT OF COMMERCE
BUREAU OF ECONOMIC RESEARCH
WASHINGTON, D. C.

OFFICE OF THE DIRECTOR
WASHINGTON, D. C.

1940

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED CERTIFICATE OF DEATH

Registration District No. **91**

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **51072**
Registered No. **24**

1. PLACE OF DEATH.

County of **Clearwater**

City of **Elk River**

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant O'Honnell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug 13 1925
(Month) (Day) (Year)

7. AGE

Still-born
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Norman O'Honnell

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.

12. MAIDEN NAME OF MOTHER

Mary Jassman

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norman O'Honnell

(Address)

Elk River, Idaho.

15.

Filed

Oct. 15 1925
Mildred Hambley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 13 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____

that I last saw h. alive on 191____

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Still birth, due to mal-position + difficult labor

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **R. J. Hoffmann** M. D.

Sep 25 1925 (Address) **Elk River, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elk River, Ida.

Aug. 14 1925

20. UNDERTAKER

ADDRESS

None.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

612-216-025-238
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho

SEP 11 1925

City of Suttonwood

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. St. Registration District No. 105 State File No. 134725

Hospital Primary Registration District No. 2183 Local Registrar's No. 61

FULL NAME OF CHILD

Ursula Wassmuth

(Certificate of no value without full name of child)

Sex of
Child

Female

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Aug 16 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 9

Number of child of this mother now living, including present birth 8

FULL
NAME

FATHER

Curtis Wassmuth

RESIDENCE

Green Creek

COLOR

white

AGE AT LAST
BIRTHDAY

40
(Years)

BIRTHPLACE

Id

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Ursula Wassmuth

RESIDENCE

Green Creek

COLOR

white

AGE AT LAST
BIRTHDAY

40
(Years)

BIRTHPLACE

Wis.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 1:30 A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Mrs. Curtis Jansen

(Signature of midwife)

Address

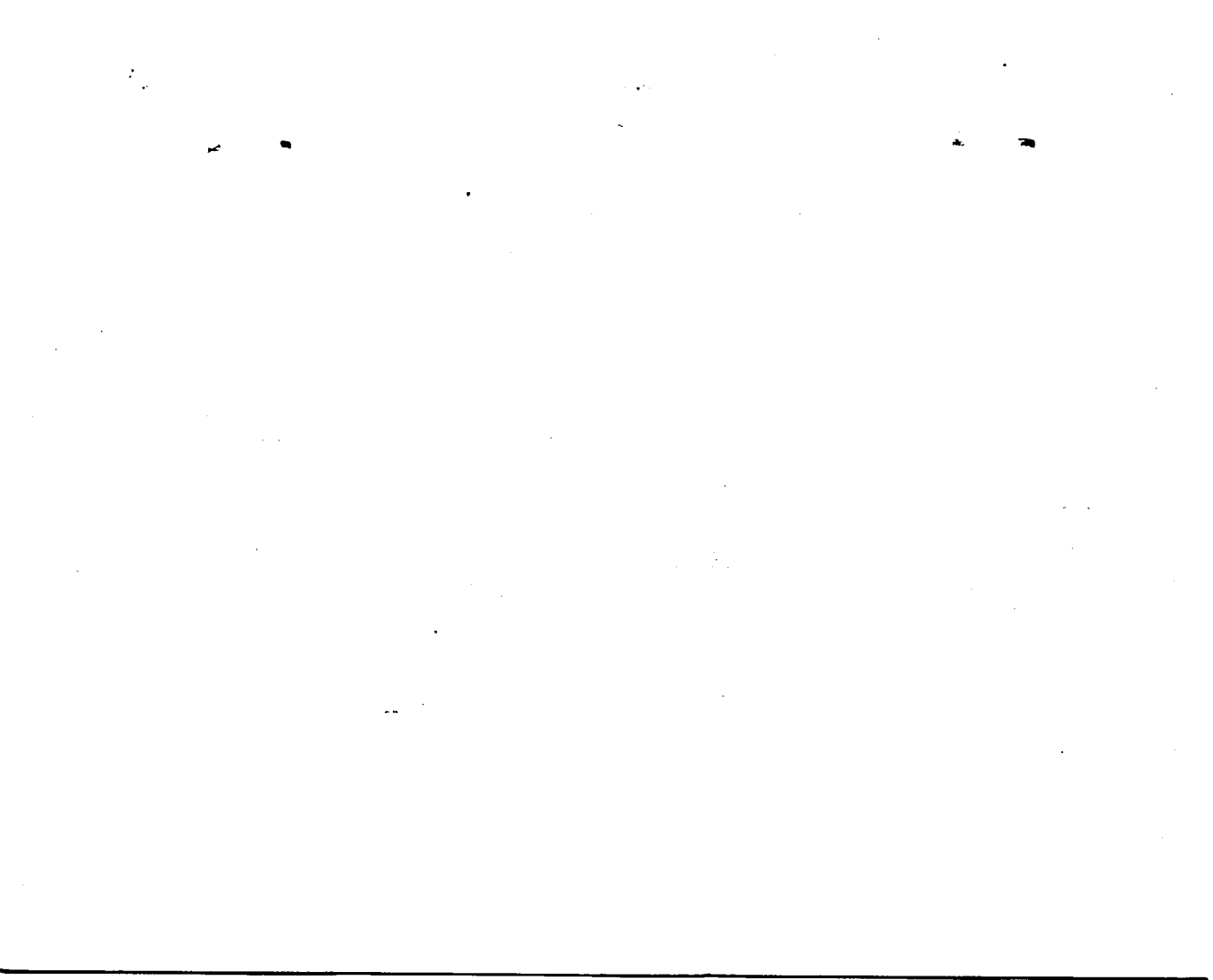
Green Creek Ida.

Filed

Sept 1925 H. F. Orr per J. B.

Registrar.

Registrar.



CERTIFICATE OF DEATH.

50749

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho District No. 105
City of Pattersonwood Registration District No. 2183 (St.)
BUREAU OF VITAL STATISTICS
SEP 11 1925File No. 19
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Anna Wassmuth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Aug 16 1925
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Anton Wassmuth

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Mrs. Anna Schaefer

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Anna Wassmuth
Green Creek, Idaho

15.

Filed

Sept. 19251925H. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 16 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Unknown
Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)(Signed) Wesley Orr M. D.8/16/25 (Address) Pattersonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Creek, Idaho 8/16 1925

20. UNDERTAKER

ADDRESS

Barney Huber, Green Creek

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

319-101-029-414

PLACE OF BIRTH

RECEIVED

SEP 14 1925

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

County of ButteBUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

City of PrincetonRegistration District No. 65File No. 134791

No. _____ St. _____

Primary Registration District No. 2145

Registered No. _____

Hospital _____

FULL NAME OF CHILD

Cecil. LazelleSex of
ChildMaleTwin
Triplet
or other?

1

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti
mate?YesDate of
BirthAug 11925

(Month) (Day) (Year)

FULL
NAME

FATHER

Ray Lazelle

RESIDENCE

FULL
MAIDEN
NAME

MOTHER

Fairy Thompson

RESIDENCE

COLOR

WhiteAGE AT LAST
BIRTHDAY3 6
(Years)

BIRTHPLACE

Washington

OCCUPATION

Wardman

COLOR

WhiteAGE AT LAST
BIRTHDAY3 2
(Years)

BIRTHPLACE

Idaho

OCCUPATION

HousewifeNumber of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____, at _____, 7 P.M.
on the date above stated. Born alive—stillborn*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

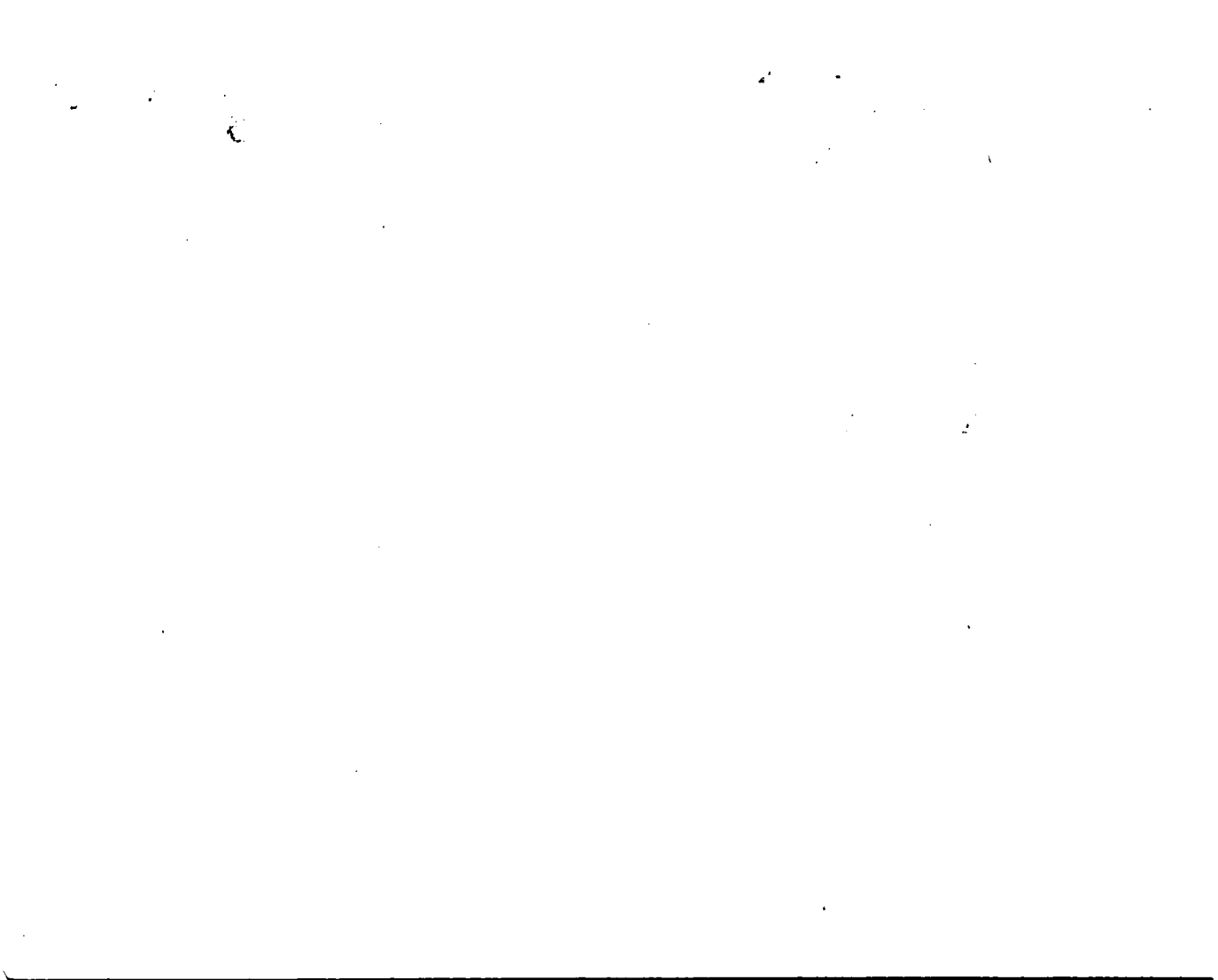
Princeton Idaho

Filed

Aug 10 1925 D. M. Thompson
Registrar

Registrar

No Death entry as per usual custom



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *Latah*
City of *Princeton*

RECEIVED

SEP 14 1925

BUREAU OF VITAL
STATISTICS

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Becil Lazelle

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *50775*

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*single*
(Write the word.)

6. DATE OF BIRTH.

Aug
(Month)*1st*
(Day)*1925*
(Year)

7. AGE

Yrs. Mos. ds.

If LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

none

9. BIRTHPLACE

(State or Country)

*Princeton*10. NAME OF
FATHER*Roy Lazelle*11. BIRTHPLACE
OF FATHER

(State or Country)

*Palouse Creek*12. MAIDEN NAME
OF MOTHER*Daisy Thompson*13. BIRTHPLACE
OF MOTHER

(State or Country)

Latah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Daisy Lazelle

(Address)

Princeton

15.

Filed

*Aug 2nd**1925**Dr J. R. Thompson*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug
(Month)*1st*
(Day)*1925*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/1 1925 (Address) *N. Book* M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Wendenhall Cemetery**Aug 2nd* 1925

20. UNDERTAKER

ADDRESS

*Parents**Princeton*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

366 1296029 PLACE OF BIRTH 386

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
STATISTICS

County of Latah

City of

No. St.

Hospital

Registration District No. 65 State File No. 134803

Primary Registration District No. 2145 Local Registrar's No.

FULL NAME OF CHILD Unnamed infant - Lower - (Stillborn)

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>n</u>	and { Number in order of birth } <u>n</u>	Legitimate? <u>yes</u>	Date of birth <u>June 29, 1925</u> (Month) (Day) (Year)
--------------------------	---------------------------------	---	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 8

FATHER
FULL NAME Geo M. Lower
RESIDENCE 6 mi. N. E. Calmar
COLOR White AGE AT LAST BIRTHDAY 45 (Years)
BIRTHPLACE Oregon
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME May Thurman
RESIDENCE Calmar
COLOR White AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Ark.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. K. Wolfe M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Calmar, Wash.

Filed July 10, 1925 J. M. Thompson Registrar.

Registrar.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL CENTER FOR HUMAN REPRODUCTION
 101 DEPT OF HEALTH AND HUMAN SERVICES
 WASHINGTON, D.C. 20001

PLACE OF BIRTH

INDIANA
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF BIRTH

2

131803

County of _____
 City of _____
 State of _____
 Hospital _____
 Primary Registration District No. _____
 Birth Date _____

FULL NAME OF CHILD

Sex of Child _____
 (To be answered only in event of plural births)
 Twin, triplet or other _____
 and in order of birth _____
 Number _____
 Legible _____
 State of birth _____
 Date of birth _____
 (Year) _____

What antiseptical solution was used in event _____

Number of child of this mother, including present birth _____
 Number of child of this mother now living, including present birth _____
 FATHER FULL NAME _____
 MOTHER FULL NAME _____
 Maiden Name _____

COLOR _____
 AGE AT LAST BIRTHDAY _____
 (Year) _____
 BIRTHPLACE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 (Year) _____
 BIRTHPLACE _____
 OCCUPATION _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 on the date above stated.

When there was no attending physician or midwife, then the father, mother, or other person should make this return. A stillborn child is one that neither breathes nor shows other evidence of the start of birth.

Signature of Physician or Midwife _____
 Date _____
 Signature of Father _____
 Date _____
 Signature of Mother _____
 Date _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

256-10-029-331
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

OCT 5 1925

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH 134811

County of *Latah*

City of *Moscow*

No. *120 So Main* St.

Hospital *The Gutman*

Registration District No. *61*

File No.

Primary Registration District No. *1011*

Registered No. *110*

FULL NAME OF CHILD

Baby Snow Skelton

(Certificate of no value without full name of child.)

Sex of Child *Male*

Twins
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Sept. 1, 1925

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Argyrol 10%

Number of child of this mother, including present birth

8

Number of child of this mother now living, including present birth

8

FULL
NAME

FATHER

Charles Cushing Snow

RESIDENCE

Tekoa, Wash.

FULL
MAIDEN
NAME

MOTHER

Alice Ann Clark

RESIDENCE

Tekoa, Wash.

COLOR

White

AGE AT LAST
BIRTHDAY

54

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

35

(Years)

BIRTHPLACE

Kansas

BIRTHPLACE

California

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Chas. L. Gutman at *3:50 a. m.*
(Child was stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Chas. L. Gutman

Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

Moscow, Id.

Filed

9-17 1925

M. H. Carithers

Registrar.

Registrar.

3

1

1

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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Salah
City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Snow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child

(Write the word.)

6. DATE OF BIRTH

Sept. 1, 1925
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Moscow Idaho

10. NAME OF FATHER

Chas. C. Snow

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Alice Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Calif.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. C. Snow

(Address)

Tukoa, Wash.

15.

Filed Sept. 2, 1925M. Barthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 1, 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 1, 1925 to Sept. 1, 1925that I last saw him alive on Sept. 1, 1925and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature birth
still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. L. Gutzgaw, M. D.9/2, 1925 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

9-2, 1925

20. UNDERTAKER

H. R. Short

ADDRESS

Moscow

MAY 26 1970

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

553-225-029-693

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED
OCT 5 1925STATE OF IDAHO
BUREAU OF VITAL STATISTICSCounty of LatahBUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

City of Hamington Wash.Registration District No. 61File No. S 134816

No. _____

St. _____

Primary Registration District No. 2141Registered No. 106

Hospital _____

FULL NAME OF CHILD Not Named (Stille-borne)Sex of
Child M.Twins
Single-
or other?
(To be answered only in event of plural births)and { Number
in order
of birth
/ }Legiti
mate? yesDate of
Birth Aug 25th

(Month)

(Day)

1925
(Year)FULL
NAME

FATHER

Alfred NelsonFULL
MAIDEN
NAME

MOTHER

Eva Wilson

RESIDENCE

Latah Co. Ida. (wash)

RESIDENCE

Latah Co. Ida (wash, P.O.)

COLOR

WhiteAGE AT LAST
BIRTHDAY33

(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY33

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Washington

OCCUPATION

Farmer

OCCUPATION

House wifeNumber of child of this mother, including present birth 6Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stilleborn, at 6 A. M.
on the date above stated. (Born alive or stillborn)*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.(Signature) W. B. Brandon M.D.Physician & Surgeon

(Physician or midwife)

Given names added from a supplemental report.

19

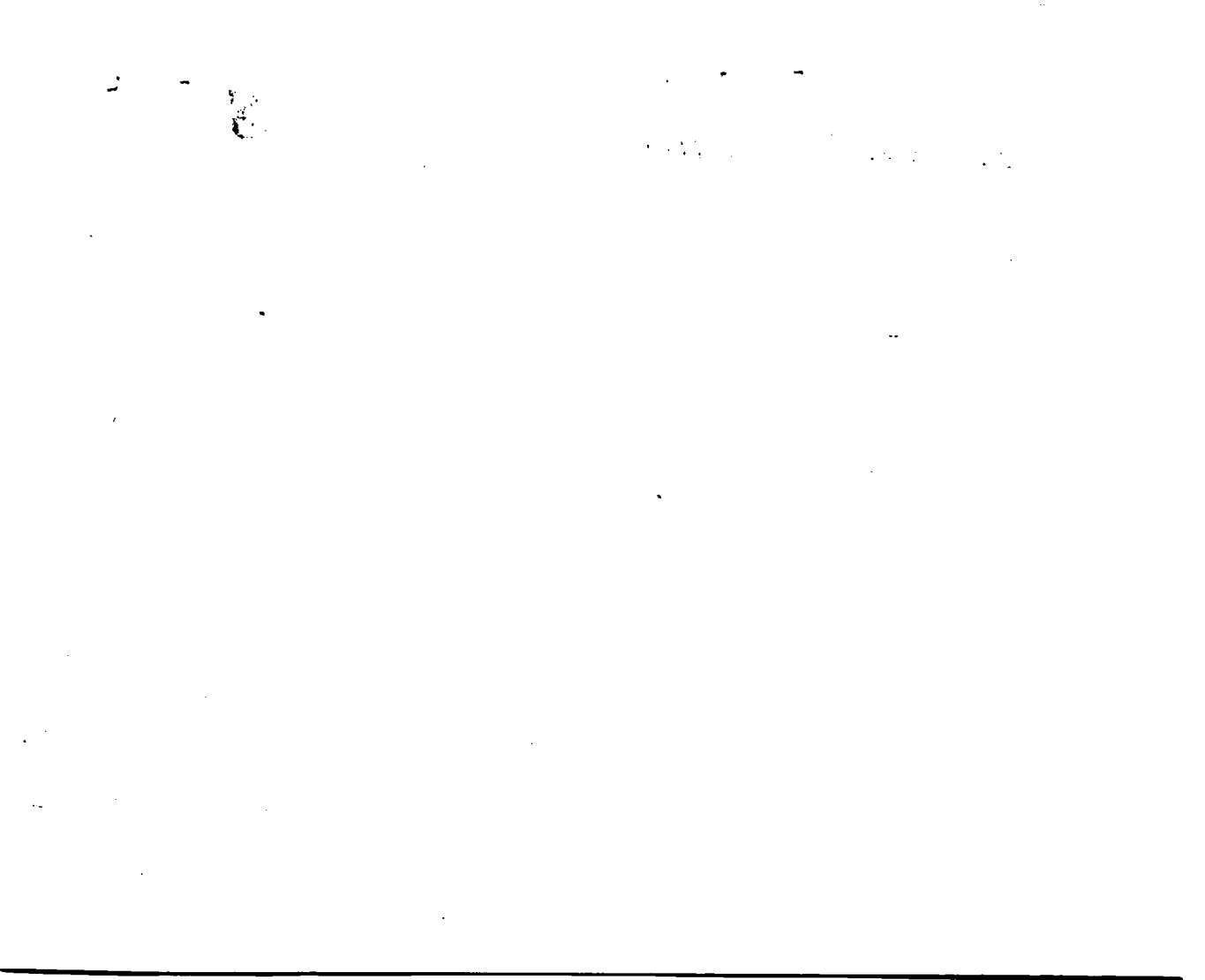
Address Garfield washFiled Sept 191925M. H. Barithers

Registrar

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
OCT 3 1925
BUREAU OF VITAL STATISTICS

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 50785
Registered No. 50

1. PLACE OF DEATH. District No. 601
County of Latah, BUREAU OF VITAL STATISTICS Registration District No. 2141
City of Garfield Wash. (No. St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Unnamed child of Alfred Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Aug. 25, 1925. (Month) (Day) (Year)

7. AGE yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Alfred Nelson

11. BIRTHPLACE OF FATHER Minnesota (State or Country)

12. MAIDEN NAME OF MOTHER Eva Wilson

13. BIRTHPLACE OF MOTHER Washington (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Alfred Nelson (Address) Garfield, Wash.

15. Sept 9 1925 M. Hoarither Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 25th 1925. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1925, to Aug 1925 that I last saw him alive on Born dead 191 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: Still born, Cause unknown

(Duration) yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) W. B. Brandon M. D. 8-25 1925 (Address) Garfield, Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Garfield, Wash. Aug. 25 1925

20. UNDERTAKER ADDRESS F. L. Swinn Garfield, Wash.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

389-204-030-921
PLACE OF BIRTH
County of Yemah
City of Salmon
No. _____ St. _____ Registration District No. 41 State File No. 134831
Hospital Salmon Tel. Hospital Primary Registration District No. 2116 Local Registrar's No. _____
FULL NAME OF CHILD _____
(Certificate of no value without full name of child)
Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth August 4 1925
(To be answered only in event of plural births) (Month) (Day) (Year)
What bactericidal solution was used in eyes? _____
Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth one
FULL NAME JAMES OLIVER CHRISTENSEN FATHER FULL MAIDEN NAME Cessie Bach MOTHER
RESIDENCE Salt Lake Utah RESIDENCE Salt Lake Utah
COLOR Wh AGE AT LAST BIRTHDAY 24 (Years) COLOR Wh AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Utah BIRTHPLACE Ida
OCCUPATION Painter OCCUPATION Hot
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was born alive Stillborn at B. P. M.
on the date above stated.
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 192_____
_____, 192_____
Registral.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
SEP 16 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Franklin*

City of *Salmon*

Registration District No. *41*

Registration District No. *2116*

St.)

File No. *50788*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born child

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH *Aug 4 1925*
(Month) (Day) (Year)

7. AGE IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Salmon*
(State or Country)

10. NAME OF FATHER *James Oliver Christensen*

11. BIRTHPLACE OF FATHER *Utah*
(State or Country)

12. MAIDEN NAME OF MOTHER *Cassie Bach*

13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *J. S. Wright*
(Address) *Salmon*

15. Filled *9/10 1925* *Clara Bellamy*
Local Registrar

16. DATE OF DEATH *Aug 4 1925*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *19* to *19*
that I last saw h. alive on *19*
and that death occurred on the date stated above, at *M.*
The CAUSE OF DEATH* was as follows:

Still born child
Cause unknown
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) *J. S. Wright* M. D.
9/4 1925 (Address) *Salmon*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Salmon Cemetery* DATE OF BURIAL *8-4 1925*

20. UNDERTAKER *J. M. E. Thibault* ADDRESS *Salmon*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

154113-031-261
PLACE OF BIRTH

RECEIVED
OCT 6 1925
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho

City of Winchester

No. _____ St. _____

Hospital _____

Registration District No. 50

File No. 134841

Primary Registration District No. 3129

Registered No. 37

FULL NAME OF CHILD _____

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twins Triplet or other? _____	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Aug 13</u> <u>1925</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? K

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Henry A Anderson

MOTHER
FULL MAIDEN NAME Zula Swarnigan

RESIDENCE Winchester Idaho

RESIDENCE Winchester Idaho

COLOR white AGE AT LAST BIRTHDAY 34 (Years)

COLOR white AGE AT LAST BIRTHDAY 37 (Years)

BIRTHPLACE N Carolina

BIRTHPLACE Idaho

OCCUPATION Construction laborer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at _____ P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. B. Duvel

(Physician or midwife)

Give names added from a supplemental report.
_____, 19_____

Registrar.

Address Craigmont Idaho
Filed 7/13 1925 R. B. Duvel Registrar.

6

2

2

2

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BenewahCity of Wendover

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATHRegistration District No. 60

BUREAU OF VITAL STATISTICS

Pinetown District No. 277(No. 277 St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 50796Local Registrar's No. 13

If death occurred in hospital, institution, or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

(Write the word)

6. DATE OF BIRTH

Aug 13 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wendover, Idaho10. NAME OF
FatherHenry Anderson11. BIRTHPLACE
OF FATHER(State or Country) Idaho12. MAIDEN NAME
OF MOTHERThelma Swanson13. BIRTHPLACE
OF MOTHER(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Anderson(Address) Wendover, Idaho

15.

Filed 7/15 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 13 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 13 1925 to Aug 13 1925

that I last saw him alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pericardial effusion
prolonged
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Anderson7/13 1925 (Address) Wendover, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wendover, Idaho 7/14 1925

20. UNDERTAKER

ADDRESS

Henry Anderson Wendover, Idaho

*Only known cause of pneumonia
the father was test matter had
severe attack Dysentery*
R.E.D.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

415-329-333 PLACE OF BIRTH 7154

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Reynolds
City of Mohrison

RECEIVED
SEP 18 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 134861

No. _____ St. _____ Registrar's No. 100 State File No. _____
Hospital _____ Primary Registration District No. 2178 Local Registrar's No. 1192

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>Yes</u>	Date of birth <u>Aug 29</u> 192 <u>5</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? 2% Oxy. NO3

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER	MOTHER
FULL NAME <u>Roy J. Davis</u>	FULL MAIDEN NAME <u>Mrs. Anderson</u>
RESIDENCE <u>Reynolds</u>	RESIDENCE <u>Reynolds</u>
COLOR _____ AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Arizona</u>
OCCUPATION <u>College Professor</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:00 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) K. B. Rigby M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed 9/12 1925

Registrar.

Registrar.

NO DC

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

41518-835-236
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED
OCT 13 1925
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 134903

County of Payson
City of Lewiston
No. V-1 St. Registration District No. 96 State File No. 134903
Hospital _____ Primary Registration District No. 1009 Local Registrar's No. _____
FULL NAME OF CHILD Fathoru
(Certificate of no value without full name of child)

Sex of Child M Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Aug-15 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 7

FATHER		MOTHER	
FULL NAME	<u>Willis R. Davis</u>	FULL MAIDEN NAME	<u>Mary A. Sloan</u>
RESIDENCE	<u>Lewiston Idha</u>	RESIDENCE	<u>Lewiston Idha</u>
COLOR	<u>W</u>	COLOR	<u>W</u>
AGE AT LAST BIRTHDAY	<u>44</u> (Years)	AGE AT LAST BIRTHDAY	<u>39</u> (Years)
BIRTHPLACE	<u>Mo.</u>	BIRTHPLACE	<u>W. Va.</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was Stillborn at 11- P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 1925

(Signature) J. M. Lytle
(Physician or midwife)
Address Lewiston Idha
Filed Oct-9 1925 Swann E. Bruce
Registrar. Registrar.

2

10 m

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

391-211-035-364
PLACE OF BIRTH

County of Payson
City of Payson
No. R-2- St. Registration District No. 95 State File No. 134905

Hospital _____ Primary Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn
(Certificate of no value without full name of child)

Sex of Child <u>F</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Sept. 11, 1925</u> (Month) (Day) (Year)
-----------------------	------------------------------	--------------------------------------	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>4</u>	Number of child of this mother now living, including present birth <u>3</u>
FATHER FULL NAME <u>Charles Crabbe</u> RESIDENCE <u>Payson Ida</u> COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>20</u> (Years) BIRTHPLACE <u>Okla.</u> OCCUPATION <u>Oil Dealer</u>	MOTHER FULL MAIDEN NAME <u>Olivera Tomlinson</u> RESIDENCE <u>Payson Ida</u> COLOR <u>Y</u> AGE AT LAST BIRTHDAY <u>28</u> (Years) BIRTHPLACE <u>Colo.</u> OCCUPATION <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn at Payson M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 1925

(Signature) J. M. Lyle
(Physician or Midwife)
Address Payson Ida
Filed Oct-9 1925 Dwan E Bruce Registrar.

10 DC

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

413-228,043-113
PLACE OF BIRTH

RECEIVED

SEP 10 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Valley

City of Alpha

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 15 State File No. 135055

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>July 28</u> 192 <u>5</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FULL NAME <u>James Arthur Matison</u>	FATHER
RESIDENCE <u>Alpha Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)
BIRTHPLACE <u>Nebraska</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Myrtle Jackson</u>	MOTHER
RESIDENCE <u>Alpha, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3:00 a. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1925

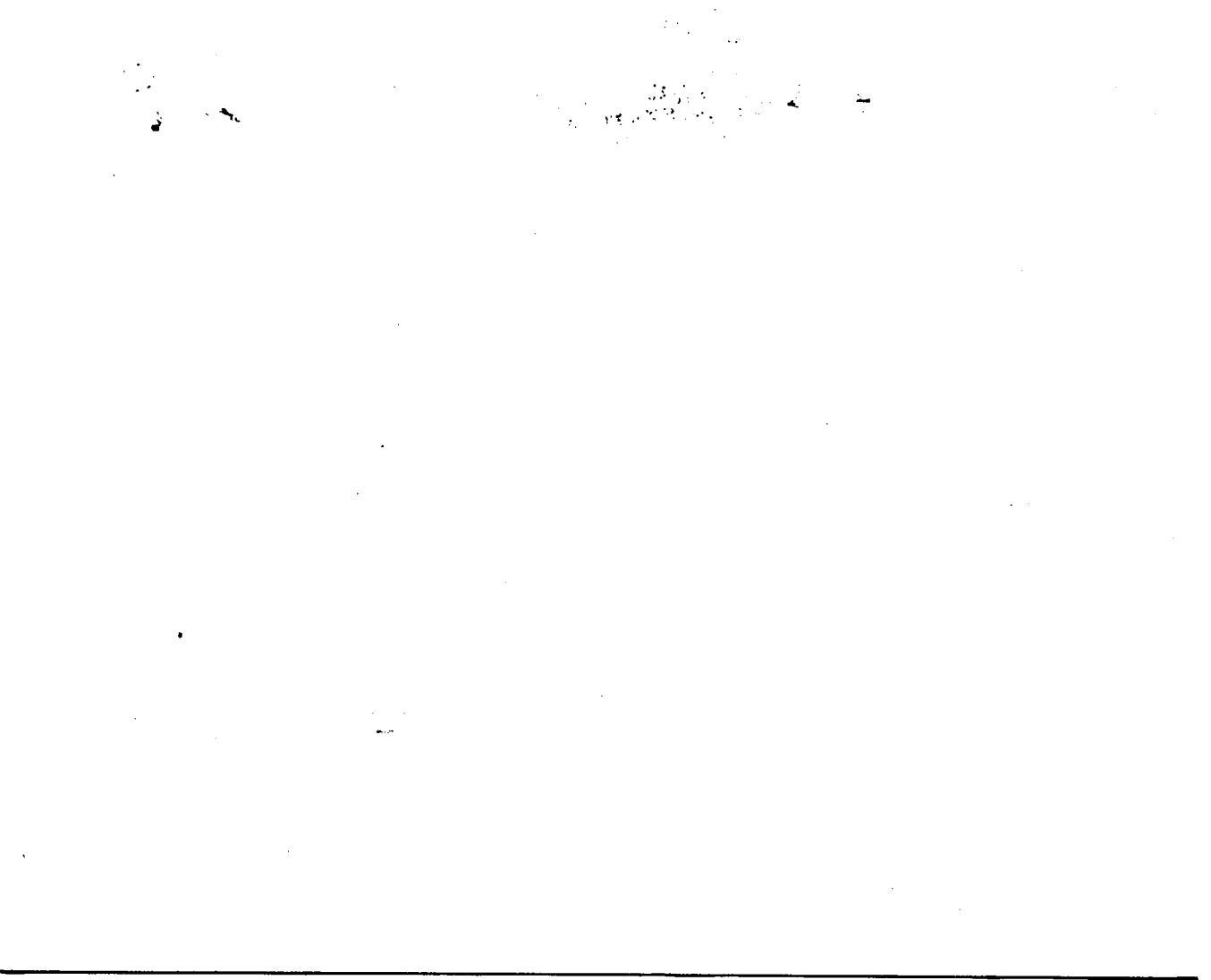
(Signature) J. F. Rutledge, M.D.
Stillborn

(Physician or midwife)

Address Cascade, Idaho

Filed Sept 7 1925 Stillborn
Refy Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Valley
City of alpha

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still birth

RECEIVED CERTIFICATE OF DEATH

SEP 10 1925

BUREAU OF VITAL STATISTICS

District No. 15

District No. -

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 50888

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

July

28

1925

(Month)

(Day)

(Year)

7. AGE

8 1/2 months (in utero)

IF LESS than 1
day how many

hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

James Arthur Matteson

11. BIRTHPLACE

OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME

OF MOTHER

Myrtle Jackson

13. BIRTHPLACE

OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. F. Rutledge

(Address)

Cascade Idaho

15.

Filed

19

Stella Cain

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

28

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at 3:00 AM

The CAUSE OF DEATH* was as follows:

Concealed Hemorrhage (abrupt placenta) necessitating forced delivery

(Duration) - yrs. - mos. - ds.

Contributory
(Secondary)

(Duration) - yrs. - mos. - ds.

(Signed)

J. F. Rutledge M. D.

7/28/1925

(Address)

Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death - yrs. - mos. - days, State - yrs. - mos. - ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of child stated.

618-214-007-249
PLACE OF BIRTH
COUNTY OF Ada
CITY OF Boise
No. 1412 Sherman St. Registration District No. 2 State File No. 135118
Hospital St. Luke's Primary Registration District No. 1.004 Local Registrar's No. 339
FULL NAME OF CHILD Baby Wayne

RECEIVED
NOV 6 1925
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Sex of Child F Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth Oct 14 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Acetic solution

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Harold Aubrey Wayne</u>	<u>Boise</u>	<u>Mary Smith</u>	<u>Boise</u>
COLOR <u>w</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>w</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Iowa</u>		BIRTHPLACE <u>Colo</u>	
OCCUPATION <u>Book Keeper</u>		OCCUPATION <u>h.w.</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 7 F 50 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) John W. Smith

(Physician or midwife)

Address Boise, Ida

Filed Oct 30 1925

Registrar.

Registrar.

11

2

11

11

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
NOV 6 1925 BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **50922**

PLACE OF DEATH

County of **Ada**

City of **Boise**

BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Registration District No. **2**

Primary Registration District No. **1003**

(No. **St. Luke's Hospital**)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. **241**

2. FULL NAME **Infant Wayne**

(a) Residence No. **1412 Sherman** St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Boise Idaho

10 NAME OF FATHER

H. A. Wayne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Colorado

14 Informant

H. A. Wayne

(Address)

1412 Sherman St.

15 File

Oct 31 1925

R. N. Bath

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 14 19**25**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 14 19**25**, to **Oct 14** 19**25**, that I last saw him alive on

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn
Cause: **Stillborn**
near to day to be delivered in time.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed)

10-15-1925 (Address) **Boise Id**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Marion Hill Cemetery

Oct. 15-1925

20 Undertaker

Address

Summers & T. Co Boise Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever, (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

389-1011-003-695
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock,

City of Pocatello

No. R. # 1 St. Regist.

Hospital

FULL NAME OF CHILD

RECEIVED
OCT 14 1925
BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

Registration No. 28 State File No. 135175

Primary Registration District No. 2161 Local Registrar's No. 7219

(Still Born.)

(Certificate of no value without full name of child)

Sex of Child Male. Twin Triplet or other? and { Number in order of birth Legiti- mate? Yes Date of birth Sept. 1 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Marvin Joseph Christensen.
RESIDENCE R # 1
COLOR White. AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Newton, Utah.
OCCUPATION Farmer.

MOTHER
FULL MAIDEN NAME Ruth Julia Winn.
RESIDENCE R # 1
COLOR White. AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Oakwood, Oklahoma.
OCCUPATION Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4:10 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. , 1925

Registrar.

(Signature) William F. Howard, M.D.

(Physician or midwife)

Address Pocatello, Idaho.

Filed 17, 1925 Registrar.

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A PASSPORT ONLY AND IS NOT VALID FOR ANY OTHER PURPOSE. IT IS NOT VALID FOR THE PURPOSE OF OBTAINING A PASSPORT IF THE HOLDER IS NOT A CITIZEN OF THE UNITED STATES.

PLACE OF BIRTH

STATE OF CALIFORNIA

RECEIVED
BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC HEALTH

OFFICE OF THE REGISTRAR

Primary Registration District No. _____
County of _____
State File No. _____
Date of Birth _____

(Continued on reverse side of this certificate)

Sex of Child _____
Color of Child _____
Date of Birth _____
Month _____
Year _____

What the child's condition was at birth

Number of this mother's previous births

FATHER
FULL NAME _____
BIRTHDAY _____
COLOR _____
OCCUPATION _____

MOTHER
FULL NAME _____
BIRTHDAY _____
COLOR _____
OCCUPATION _____

RESIDENCE _____

ADDRESS _____

DATE OF BIRTH _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

DATE OF LAST BIRTHDAY _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
(Signature) _____

(Physician or Midwife)

(Physician or Midwife)

(Physician or Midwife)

(Physician or Midwife)

(Physician or Midwife)

(Physician or Midwife)

Give names and from a supplemental report
shows other evidence of this child
child is one that neither parent nor
mother should make this return. A stillborn
or midwife then the father householder
When there was no attending physician
on the date above stated.

192

Registrar

Filed

192

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH
County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
CERTIFICATE OF DEATH
Registration District No. 28
2161
BUREAU OF VITAL STATISTICS
(No. 2161 St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 50892
Local Registrar's No. 1661

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

(Still Born) Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Still Born
(Write the word)

6. DATE OF BIRTH Sept 1 1925
(Month) (Day) (Year)

7. AGE Still born IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds. None

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bannock Co, Idaho

10. NAME OF FATHER Marvin Joseph Christensen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ruth Wynn

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marvin J. Christensen
(Address) Pocatello Idaho

15. Filed 9-1 1925 J. H. Manning
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 1 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1925 to Sept 1 1925 that I last saw him Still born Sept 1 1925 and that death occurred on the date stated above, at 4:10 P.M. The CAUSE OF DEATH* was as follows:

Exhaustion
Long labor 60 hrs. 11/10 died 19 yr. mother, primipara, cord 2 mos. amnion
(Duration) yrs. mos. ds.

Contributory (Secondary) Same
(Duration) yrs. mos. ds.

(Signed) W. J. Howard M. D.
9-1-1925 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the of death yrs. mos. days, State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Pocatello DATE OF BURIAL 9-1 1925

20. UNDERTAKER M. J. Christensen (father) ADDRESS Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED		STATE OF IDAHO		S	
419 126 203 553		OCT 14 1925		DEPARTMENT OF PUBLIC WELFARE		BUREAU OF VITAL STATISTICS	
County of <u>Bannock</u>		BUREAU OF VITAL STATISTICS		CERTIFICATE OF BIRTH		135212	
No. _____	St. _____	Registration District No. _____	28	State File No. _____			
Hospital <u>General</u>	Primary Registration District No. _____	2161	Local Registrar's No. _____	2256			
FULL NAME OF CHILD <u>Babe Martin (Stillborn)</u>							
(Certificate of no value without full name of child)							
Sex of Child <u>M</u>	Twin Triplet or other? <u>-</u>	and { Number in order of birth <u>-</u> }	Legitimate? <u>Yes</u>	Date of birth <u>9 - 26 1925</u>			
				(Month) (Day) (Year)			
What bactericidal solution was used in eyes? <u>none</u>							
Number of child of this mother, including present birth <u>1</u>			Number of child of this mother now living, including present birth <u>0</u>				
FATHER			MOTHER				
FULL NAME <u>Malcolm J. Martin</u>			FULL MAIDEN NAME <u>Selma Nelson</u>				
RESIDENCE <u>Pocatello</u>			RESIDENCE <u>Pocatello</u>				
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>31</u> (Years)			COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)				
BIRTHPLACE <u>Salt Lake City</u>			BIRTHPLACE <u>Idaho Falls</u>				
OCCUPATION <u>Sheepman</u>			OCCUPATION <u>N. A.</u>				
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE							
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>10 P.</u> M. on the date above stated.							
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.							
Give names added from a supplemental report.							
_____, 1925							
Address <u>Pocatello</u>							
Filed <u>19</u> 1925 <u>W. J. Young</u>							
Registrar. Registrar.							

8-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Malcolm Morton Jr.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 50903

Local Registrar's No. 4672

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

single
(Write the word)

6. DATE OF BIRTH

Sept 27 1925
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF
Father

Malcolm Morton

11. BIRTHPLACE
OF FATHER

(State or Country)

Salt Lake Utah

12. MAIDEN NAME
OF MOTHER

Selma Nelson

13. BIRTHPLACE
OF MOTHER

(State or Country)

Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Malcolm Morton Jr.
Pocatello, Ida.

15.

Filed Sept 27 1925

J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 27 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7-26 1925, to 19,

that I last saw him alive on 19,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

7/28 (Signed) J. P. Young M. D.
1925 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or
usual residence Pocatello, Ida.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem.

Sept 27 1925

20. UNDERTAKER

ADDRESS

McKinnon & Co. Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

117

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO		S
DEPARTMENT OF PUBLIC WELFARE		BUREAU OF VITAL STATISTICS		
86-112004-294		RECEIVED		
County of <u>Ben Lape</u>		OCT 17 1925		
City of <u>Georgetown</u>		BUREAU OF VITAL STATISTICS		CERTIFICATE OF BIRTH
No. _____	St. _____	Reg. _____	No. <u>52</u>	State File No. <u>135222</u>
Hospital _____		Primary Registration District No. <u>2136</u>		Local Registrar's No. _____
FULL NAME OF CHILD <u>Inf. Hoff (Not named)</u> (Certificate of no value without full name of child)				
Sex of Child <u>Male</u>	Twin Triplet or other? <u>✓</u> and { Number in order of birth _____	Legiti-mate? <u>yes</u>	Date of birth <u>July 12</u> 192 <u>5</u> (Month) (Day) (Year)	
What bactericidal solution was used in eyes? <u>none</u>				
Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>0</u>		
FATHER		MOTHER		
FULL NAME <u>Evan Hoff</u>		FULL MAIDEN NAME <u>Hana Bruce</u>		
RESIDENCE <u>Georgetown</u>		RESIDENCE <u>Georgetown</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>54</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>72</u> (Years)	
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>farmer</u>		OCCUPATION <u>housewife</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*				
I hereby certify that I attended the birth of this child, who was { Born alive } at <u>7:40 A.</u> M. on the date above stated. { Stillborn }				
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.				
Give names added from a supplemental report. _____, 192 <u>5</u>				
Address <u>Sala Springs</u>		Filed <u>10/10/</u> 192 <u>5</u>		
Registrar. _____		Registrar. <u>H. H. King</u>		

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE IDAHO VITAL STATISTICS ACT, AND IS NOT VALID FOR ANY OTHER PURPOSE.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

RECEIVED

OCT 17 1922

BUREAU OF VITAL STATISTICS OF IDAHO

County of _____

No. _____

Primary Registration District No. _____

NAME OF CHILD

Sex of Child

and in cases of twins or triplets only in words of plural birth

Legal Date

(Date of no name without name of child)

Date of Birth (Month) (Day) (Year)

and bacterial solution was used in eyes

Signature of child or his mother, father or other person in whose name the child is being registered

FATHER

FULL MAIDEN NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY (Years)

COLOR

AGE AT LAST BIRTHDAY (Years)

BIRTH DATE

BIRTH DATE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

on the date above stated.

*When there was no attending physician or midwife, then the father, household or mother should make this return. A child born alive is one that neither breathes nor shows other evidence of life at birth. The names added from a supplemental report.

(Signature of mother)

(Signature)

Address

Filed _____ 1922

Registered

2

132522

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bear Lake RECEIVEDCity of Bonington OCT 17 1925No. 219104004759 St. BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 52 State File No. 135240Hospital..... Primary Registration District No. 2136 Local Registrar's No.....FULL NAME OF CHILD Baby Spairo

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Aug 4</u> , 192 <u>5</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	---

What bactericidal solution was used in eyes? ster BoruNumber of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FULL NAME <u>Isaac W. Spairo</u>	FATHER	FULL MAIDEN NAME <u>Ruby Perkins</u>	MOTHER
RESIDENCE <u>Bonington Ida</u>		RESIDENCE <u>Bonington Ida</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>49</u> (Years)
BIRTHPLACE <u>Ida</u>		BIRTHPLACE <u>Ida</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1000 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. H. KingAddress Morefield, IdahoFiled 10/1/25 1925

Registrar.

Registrar.

THIS IS A PERMANENT RECORD
more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED
 COUNTY OF ...
 DEPT. OF HEALTH
 BUREAU OF VITAL STATISTICS
 1925

PLACE OF BIRTH

RECEIVED

OCT 17 1925

CERTIFICATE OF BIRTH

132540

Primary Registration District No. ...
 Date of Birth ...
 Sex of Child ...
 Color ...
 Birthplace ...
 Occupation ...

Full Name of Child ...
 Date of Birth ...
 Sex of Child ...
 Color ...
 Birthplace ...
 Occupation ...

Full Name of Mother ...
 Date of Birth ...
 Sex of Mother ...
 Color ...
 Birthplace ...
 Occupation ...

Full Name of Father ...
 Date of Birth ...
 Sex of Father ...
 Color ...
 Birthplace ...
 Occupation ...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was ...
 Signature ...

Address ...
 Date ...
 Registrar ...

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

OCT 17 1925

BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

50972

File No.

Registered No.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Speirs (not named)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filled

19

Local Registrar

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Still Born Macerated Fetus
about 8 mos Gestation. Cause
of Death Unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of

City of

No. 389 108 006 943 St.

Registration District No. 121

State File No. 135263

Hospital

Primary Registration District No. 2194

Local Registrar's No. 301

FULL NAME OF CHILD

Arnold Christensen

(Certificate of no value without full name of child.)

Sex of Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

Legitimacy

yes

Date of birth

Aug 8, 1925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Argyrol 10%

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

6

FULL NAME

Louis Peter Christensen

FATHER

FULL MAIDEN NAME

Guaranda Eliza Ruthe

MOTHER

RESIDENCE

Shelley Ida.

RESIDENCE

Shelley Ida.

COLOR

White

AGE AT LAST BIRTHDAY

48 (Years)

COLOR

White

AGE AT LAST BIRTHDAY

43 (Years)

BIRTHPLACE

Utah

BIRTHPLACE

Logan Utah

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Stillborn~~ at 2:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

D. H. Robert

Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Shelley Ida.

Filed

Oct 14 1925 M. L. L. E. R. R.

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED IN EXAMINING A NE BIRT—MRT AGGAGATE WITH VERNALY STAMPS
 TO BE USED IN EXAMINING A BIRT IN BIRTH AND THEN TO BE SENT TO—M. R.
 TO BE SENT TO THE BIRT OF THE BIRT IN EXAMINING THE BIRT OF THE BIRT

CITY OF _____
 COUNTY OF _____
 STATE OF _____
 1935-36
 CERTIFICATE OF BIRTH

NAME OF CHILD		SEX OF CHILD	
DATE OF BIRTH		PLACE OF BIRTH	
MOTHER'S NAME		FATHER'S NAME	
MOTHER'S RESIDENCE		FATHER'S RESIDENCE	
MOTHER'S BIRTHPLACE		FATHER'S BIRTHPLACE	
MOTHER'S OCCUPATION		FATHER'S OCCUPATION	
MOTHER'S COLOR		FATHER'S COLOR	
MOTHER'S AGE AT LAST BIRTHDAY		FATHER'S AGE AT LAST BIRTHDAY	
MOTHER'S BIRTHPLACE		FATHER'S BIRTHPLACE	
MOTHER'S OCCUPATION		FATHER'S OCCUPATION	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ on the _____ day of _____, 1935.

When there was no attending physician or midwife, then the father, mother, or other person, should make the report. A statement of the birth of this child is one that should be made. A statement of the birth of this child is one that should be made.

Signature of _____
 Address _____
 Filed _____
 Registrar _____

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of BinghamCity of WoodvilleNo. 945-208006-465

BUREAU OF VITAL

STATISTICS

NOV 7 1925

CERTIFICATE OF BIRTH 135273

Hospital

Primary Registration District No. 2194Local Registrar's No. 311

FULL NAME OF CHILD

BESSIE DAWN Huntsman

(Certificate of no value without full name of child)

Sex of Child

Twin ☒ Triplets ☒ or other?and { Number in order of birth / 57 }Legitimate? yes

Date of birth

(Month) 7 (Day) 8 (Year) 1925

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3Number of child of this mother now living, including present birth 2

FULL NAME

FATHER

Vernal Huntsman

RESIDENCE

Woodville

COLOR

W.AGE AT LAST BIRTHDAY 26 (Years)

BIRTHPLACE

Utah

OCCUPATION

Merchant

FULL MAIDEN NAME

MOTHER

Grace Montague

RESIDENCE

Woodville

COLOR

W.AGE AT LAST BIRTHDAY 26 (Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } { Stillborn } at 745 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Edwin Cutler M.D.

(Physician or midwife)

Address

Shelley, Ida

Filed

Oct 16 1925 Wm. W. E. Patton

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

JAN 20 1947

10102

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

599 125 011234
PLACE OF BIRTH

RECEIVED
NOV 9 1925
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Boundary
City of Commerce Ferry
No. 79 St. Registration District No. 79 State File No. 135354
Hospital Commerce Ferry Primary Registration District No. 315 Local Registrar's No. 1
FULL NAME OF CHILD Ernest Sheldon Virak

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth Legitimate? Yes Date of birth Sept 25 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Earl N. Virak
RESIDENCE Commerce Ferry Idaho
COLOR White AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE Wisconsin
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Beatrice Minnie Strick
RESIDENCE Commerce Ferry Idaho
COLOR White AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE California
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1:30 PM on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Ken Bowser

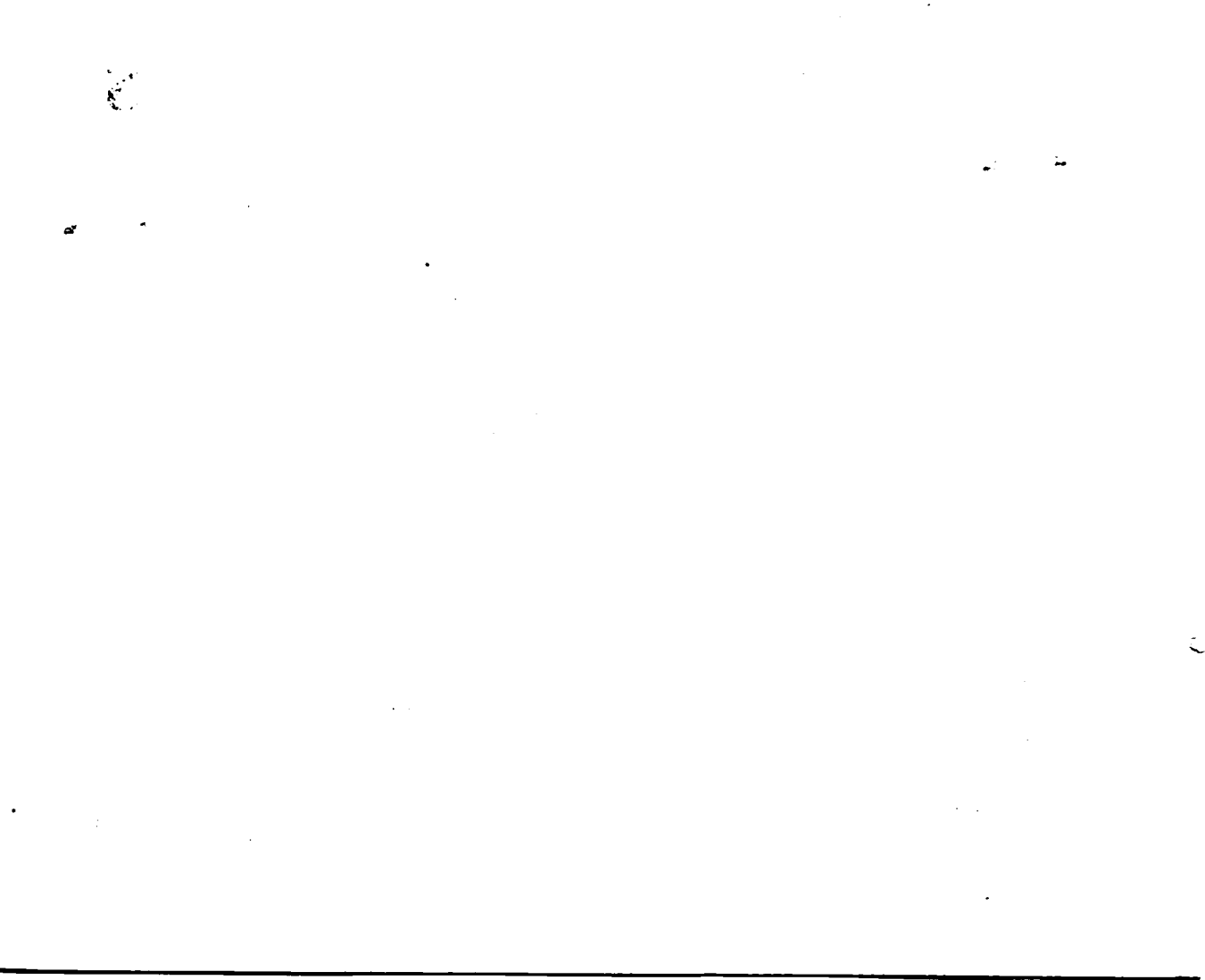
(Physician or midwife)

Address Commerce Ferry Idaho

Filed 9/28 1925

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Boundary,
City of Bonners Ferry,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Everett Theodore Virak,

CERTIFICATE OF DEATH

RECEIVED
Registration District No. 79
Primary Registration District No. 2156
St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51049
Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male, White, (Write the word)

6. DATE OF BIRTH

September, 25, 1925.
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Stillborn.

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bonners Ferry, Ida.

10. NAME OF

Father Carl Nedmark Virak,

11. BIRTHPLACE

OF FATHER
(State or Country) Wisconsin,

12. MAIDEN NAME

OF MOTHER Beatrice Minnie Stubbs.

13. BIRTHPLACE

OF MOTHER
(State or Country) California.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl M. Virak.

(Address) Bonners Ferry Ida.

15.

Filed Sept. 25th 1925.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 25, 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19,

that I last saw him alive on 19,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

Placental Infarct

(Duration) yrs. mos. ds.

(Signed)

R. M. Bowell M. D.

9/25 1925 (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonners Ferry, Ida.

Sept. 25, 1925

20. UNDERTAKER

ADDRESS

G. M. Peterson Bonners Ferry

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

NOV 2 1925

BUREAU OF VITAL

CERTIFICATE OF BIRTH

STATISTICS

No. 493-22201122 District No. 29 State File No. 135401

Hospital Primary Registration District No. 3156 Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child	Female	Twin Triplet or other?		and	Number in order of birth	1	Legitimate?	yes	Date of birth	Mar. 22 1925
										(Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Agno 3

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	George Wilson	FULL MAIDEN NAME	Ida Babb
RESIDENCE	Naples, Ida.	RESIDENCE	Naples, Ida.
COLOR	white	COLOR	white
AGE AT LAST BIRTHDAY	40 (Years)	AGE AT LAST BIRTHDAY	18 (Years)
BIRTHPLACE	Idaho.	BIRTHPLACE	Idaho.
OCCUPATION	woodman	OCCUPATION	Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 8 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Bonners Ferry, Ida.

Filed 3/23/1925 [Signature] Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made
each and the number of each, in order of birth stated.

PLACE OF BIRTH

PLACE OF BIRTH

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Boundary
City of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

March 22 1925
(Month) (Day) (Year)

7. AGE

Stillborn

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Naples, Idaho

10. NAME OF FATHER

G. H. Wilson

11. BIRTHPLACE OF FATHER

(State or Country) Minn.

12. MAIDEN NAME OF MOTHER

Ida Babb

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. H. Wilson.(Address) Naples, Idaho.

15.

Filed Mar. 23rd 1925E. S. Fry
Local Registrar

RECEIVED

NOV 2 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 79
Registration District No. 2156
(No. St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 51031

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 22 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Degeneration of placenta

(Duration) Yrs. mos. ds.

Contributory (Secondary) Influenza in mother(Duration) yrs. mos. 10 ds.(Signed) E. S. Fry M. D.3/23 1925 (Address) Bonners Ferry, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

McArthur, Idaho. March 23 192520. UNDERTAKER ADDRESS
A. McArthur, Bonners Ferry, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Cassia

NOV 4 1925

City of Bo. Bridge

BUREAU OF VITAL STATISTICS

No. 632 716 016 763Registration District No. 119State File No. 135458

Hospital

Primary Registration District No. 248

Local Registrar's No.

FULL NAME OF CHILD

Ernest Olson

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?Twinand { Number
in order
of birth2Legiti-
mate?yesDate of
birthSept. 16, 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1FULL
NAME

FATHER

Frank Olson

RESIDENCE

Bridge, Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY29
(Years)

BIRTHPLACE

Idaho

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Mary Geneva Jolley

RESIDENCE

Bridge, Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY26
(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1:00 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Leah Trazar
Physician
(Physician or midwife)

Address

Rupert, Idaho

Filed

Nov 1, 1925

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

COUNTY OF ... STATE OF ...
 I hereby certify that I attended the birth of this child, who was ...
 on the date above stated.
 When there was no attending physician ...
 I should make this return. A child born ...
 could be one that neither promises nor ...
 shows other evidence of the latter kind.
 Give names added from a supplemental report.
 M. B. ...
 1901

PLACE OF BIRTH

STATE OF ...

County of ...
City of ...

CERTIFICATE OF BIRTH

Hospital

Full Name of Child

Sex of Child

(To be answered only in case of physical defects)

What method of delivery was used in case of ...

Names of child's mother, including present name

FATHER

Names of child's mother, including present name

MOTHER

COLOR

AGE AT LAST BIRTHDAY

COLOR

AGE AT LAST BIRTHDAY

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(Signature of midwife)

Signature

1901

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

319-208.021-363
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin
City of Preston
No. St. Registration District No. 27 State File No. 135505
Hospital Primary Registration District No. 2119 Local Registrar's No. 2229

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	<u>Twin</u> <u>Triplet</u> or other? <u> </u>	} and { <u>Number</u> in order of birth <u> </u>	Legiti- mate? <u>Yes</u>	Date of birth <u>Oct. 8, 1925</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME

Willard Urvin Larsen

RESIDENCE

Preston, Idaho R.F.D. #3

COLOR

White

AGE AT LAST

BIRTHDAY

27

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farming

MOTHER
FULL MAIDEN
NAME

Ethel Cole

RESIDENCE

Preston, Idaho. R.F.D. # 5

COLOR

White

AGE AT LAST

BIRTHDAY

27

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 7 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Physician

(Physician or midwife)

Preston, Idaho

Address

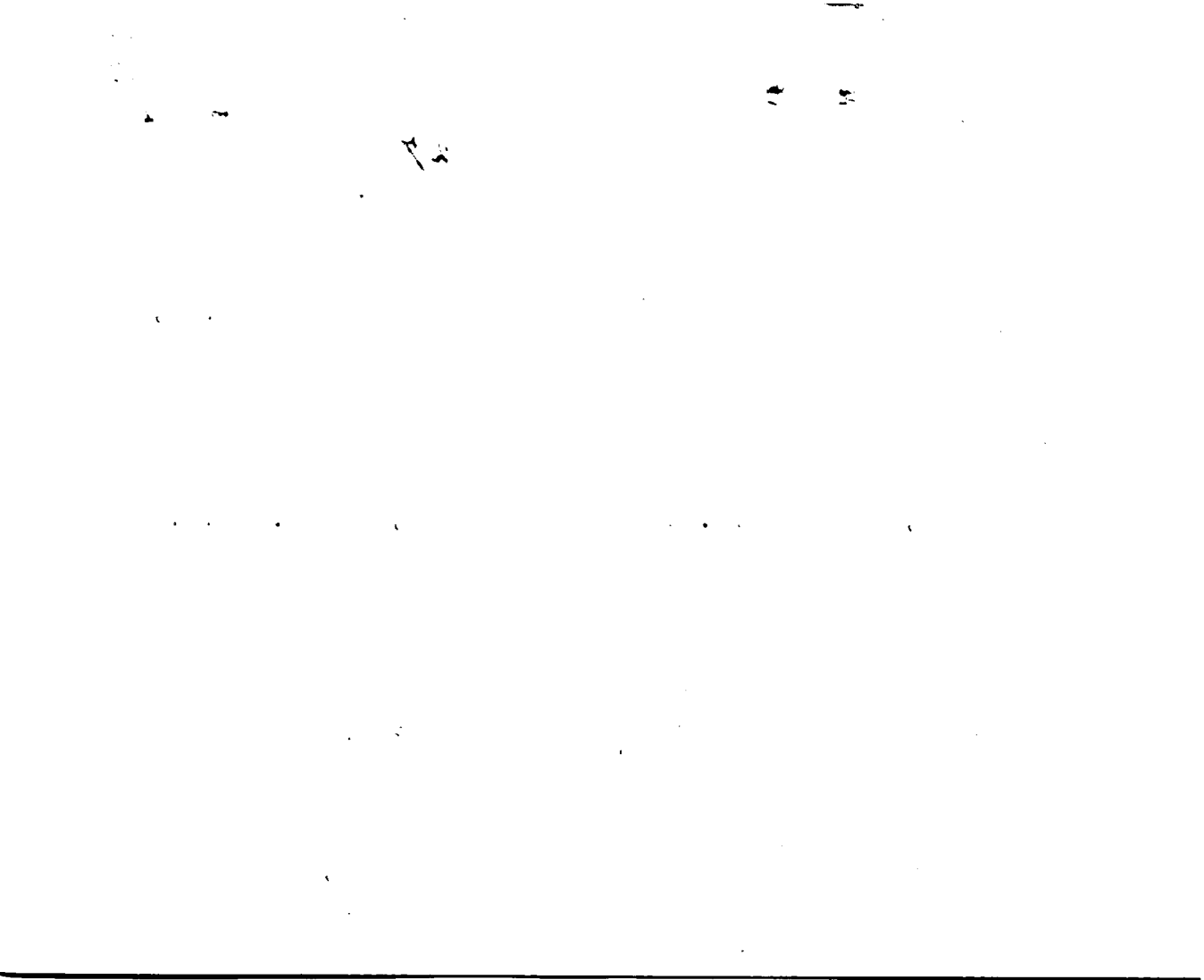
Filed

Nov. 9

1925

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 9 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

St.)

2. FULL NAME Stillborn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51084

Local Registrar's No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Single 5. SINGLE, MARRIED, WID-OWED OR DIVORCED
(Write the word)

6. DATE OF BIRTH October 8, 1925
(Month) (Day) (Year)

7. AGE 1 IF LESS than 1 day how many hrs. or min.?
(Yrs. Mos. ds.)

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Preston, Idaho

10. NAME OF Father Willard Urvin Larsen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ethel Cole

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Urvin Cole

(Address) Preston, Idaho, P. O. No. 43

15. Filled Nov. 3, 1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 8, 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1925 to Oct 8, 1925, that I last saw him alive on Oct 5, 1925, and that death occurred on the date stated above, at 5:15 M.

The CAUSE OF DEATH* was as follows:
Asphyxia

(Duration) yrs. mos. ds.
Contributory Pneumonia
(Secondary)
(Duration) yrs. mos. ds.
(Signed) A. R. Cutler M. D.
10-9-1925 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Life In the
of death Life mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Fairview Cemetery, Idaho DATE OF BURIAL Oct. 9, 1925

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, Foreman, Manager, Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**") **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, Anaemia**" (merely symptomatic), "**Atrophy, Collapse, Coma, Convulsions, Debility, Congenital, Senile, etc., Dropsy, Exhaustion, Heart Failure, Hemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

385-113-026-459
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jefferson
City of Idaho Falls
No. 98 St. BUREAU OF VITAL STATISTICS District No. 98 State File No. 35533
Hospital Idaho Falls Primary Registration District No. 2176 Local Registrar's No. 703

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? no and { Number in order of birth 1 Legiti- mate? yes Date of birth 8/18 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

FATHER		MOTHER	
FULL NAME	<u>Levan Cherry</u>	FULL MAIDEN NAME	<u>Blanche Merrill</u>
RESIDENCE	<u>Mevon</u>	RESIDENCE	<u>Mevon</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>27</u> (Years)	AGE AT LAST BIRTHDAY	<u>27</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Merchant</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1925

Registrar.

(Signature)

(Physician or midwife)

Address

Filed

Nov 10 1925

Registrar.

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of JeffersonCity of Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDInfant
(Write the word.)

6. DATE OF BIRTH

8 13 1925
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day

how many _____ hrs.

or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Levar Cherry

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Blanche Merrill

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Nov 10 1925Ray H. Fisher
Local Registrar

CERTIFICATE OF DEATH

Registration District No. 98Registration District No. 2176

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 51004Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 13 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. _____ alive on _____ 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Charles S. Moody M. D.1925 (Address) Rigby

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

962-112.026-415
PLACE OF BIRTH

County of Jefferson

City of Rigby

No. _____ St. _____

Hospital _____

RECEIVED
NOV 5 - 1925
BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Registration District No. 98 State File No. _____

Primary Registration District No. 2176 Local Registrar's No. 87

CERTIFICATE OF BIRTH
135544

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child m { Twin Triplet or other? } and { Number in order of birth } Legitimate? Yes Date of birth Oct 12 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 6

FATHER
FULL NAME Ephraim A. Zobell
RESIDENCE Rigby
COLOR White AGE AT LAST BIRTHDAY 50 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Stella Davis
RESIDENCE Rigby
COLOR White AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 192_____

Registrar.

(Signature) Ray H. Fisher
(Physician or midwife)

Address Rigby
Filed Nov 1 1925 Ray H. Fisher
Registrar.

UNOCCUPIED TERRITORY A SUFFICIENTLY LARGE AREA WITH VARIOUS ETHNIC
POPULATIONS OF EUROPEAN DESCENT AND IN WHICH ONE HAD A RIGHT TO SETTLE IN IT.
-English tried to restore it, thus to reduce the war zone

*When there was no attending physician or nurse, then the patient would be attended to by a nurse. A nurse would be called in if the patient was not able to take care of himself. If the patient was not able to take care of himself, then the nurse would be called in. If the patient was not able to take care of himself, then the nurse would be called in. If the patient was not able to take care of himself, then the nurse would be called in.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

(b) (7)(D), (b) (7)(F)

(b) (5) DPP

FATHER		MOTHER	
NAME	FULL MAIDEN NAME	NAME	FULL MAIDEN NAME
RESIDENCE		RESIDENCE	
COLOR	AGE AT LAST BIRTHDAY (Years)	COLOR	AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE		BIRTHPLACE	
OCCUPATION		OCCUPATION	

What international coalition was used in 1993

[illegible]

There is no name without the name of the

Interplay

10

10 2359

30-21490

ATTENTION TO HEALTH

DEPARTMENT OF JUSTICE
BUREAU OF PRISONS

INVESTIGATION

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of

Jefferson
Rigby

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDInfant
(Write the word.)

6. DATE OF BIRTH

Oct.

(Month)

12

(Day)

1925

(Year)

7. AGE

Stillborn

Yrs.

Mos.

ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ephraim A. Zobell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Stella Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. A. Zobell

(Address)

Rigby

15.

Filed

Nov. 10 1925

Ray H. Fisher

Local Registrar

CERTIFICATE OF DEATH

Registration District No.

98

Primary Registration District No.

2176

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 51905

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

(Month)

12

(Day)

1925

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him..... alive on

19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Ray H. Fisher M. D.

19..... (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.....

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

212-106-040-513 PLACE OF BIRTH		RECEIVED NOV 4 1925 BUREAU OF VITAL STATISTICS		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		S	
County of <u>Shoshone</u>		City of <u>Tello 99</u>		CERTIFICATE OF BIRTH 35761			
No.		St.		Registration District No. <u>123</u>		State File No.	
Hospital <u>Yes</u>		Primary Registration District No. <u>2201</u>		Local Registrar's No. <u>154</u>			
FULL NAME OF CHILD <u>No Name</u> (Certificate of no value without full name of child)							
Sex of Child <u>M</u>		Twin Triplet or other? <u> </u>		Number in order of birth <u>1</u>		Legitimate? <u>Yes</u>	
		(To be answered only in event of plural births)				Date of birth <u>Oct 6</u> 192 <u>5</u> (Month) (Day) (Year)	
What bactericidal solution was used in eyes?							
Number of child of this mother, including present birth <u>1</u>				Number of child of this mother now living, including present birth <u>0</u>			
FULL NAME FATHER <u>Fred Baker</u>				FULL MAIDEN NAME MOTHER <u>Neva Hatfield</u>			
RESIDENCE <u>B.O. Enaville Ida</u>				RESIDENCE <u>Enaville Ida</u>			
COLOR <u>White</u>		AGE AT LAST BIRTHDAY <u>37</u> (Years)		COLOR <u>White</u>		AGE AT LAST BIRTHDAY <u>31</u> (Years)	
BIRTHPLACE <u>New York</u>				BIRTHPLACE <u>Ohio</u>			
OCCUPATION <u>Rail Road man</u>				OCCUPATION <u>House wife</u>			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE							
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>2</u> P. M. on the date above stated.							
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }							
Give names added from a supplemental report., 192....							
Address							
Filed <u>Oct 31</u> 192 <u>5</u> <u>Mr. Helen M. Beede</u> Registrar. Registrar.							

THIS IS A PRELIMINARY REPORT
 TO BE USED FOR STATISTICAL PURPOSES ONLY
 AND NOT FOR LEGAL PURPOSES
 THE STATE OF OHIO
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

STATE OF OHIO
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____
 County of _____
 City of _____
 Hospital _____
 Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

(Certificate to be signed without full name of child)

Sex of Child _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____
 (Month) (Day) (Year)

What bacteriological solution was used in event

Number of child of this mother, including present birth _____
 Number of child of this mother, including present birth _____

FATHER FULL NAME _____
 MOTHER FULL NAME _____

RESIDENCE _____
 RESIDENCE _____

COLOR _____
 COLOR _____

BIRTHPLACE _____
 BIRTHPLACE _____

OCCUPATION _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____
 on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Give names added from a supplemental report.)

(Physician or midwife)

Registrar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Blaine Registration District No. 123
City of Blaine Registration District No. 2201
(No.) 51171 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Baker

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 32201Local Registrar's No. 5-2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

Oct 6 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
Father

Fred E Baker

11. BIRTHPLACE
OF FATHER

(State or Country)

New York

12. MAIDEN NAME
OF MOTHER

Neva Hatfield

13. BIRTHPLACE
OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Fred E. Baker
Barley Ave

15.

Filed

Oct. 31

1925

Local Registrar

20. UNDERTAKER

McL...

ADDRESS

Blaine

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 6 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19... to 19...
that I last saw him alive on 19...
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Mason M. D.

1925 (Address) Blaine, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1925

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)**. For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

693-110-030-295
PLACE OF BIRTH

RECEIVED

OCT 14 1925

DEPA.

BUREAU

S

135657

County of Louis

City of Salina

No. _____ St. _____

Hospital _____

BUREAU OF VITAL CERTIFICATION
STATISTICS

Registration District No. 41

Primary Registration District No. 216

File

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>in</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 10</u> (Month) (Day) (Year) <u>1925</u>
(To be answered only in event of plural births)					

What bacterioidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME George Duin Nelson
RESIDENCE Salina

COLOR white AGE AT LAST BIRTHDAY 24
(Years)

BIRTHPLACE Rumigovian

OCCUPATION Common laborer

MOTHER
FULL MAIDEN NAME Beatrice Howard King
RESIDENCE Salina

COLOR white AGE AT LAST BIRTHDAY 24
(Years)

BIRTHPLACE Idaho

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Chas F Hammer

Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Salina

Filed

10/10 -

1925

Chas Bellamy

Registrar.

Registrar.

1002

981-113-040-633 PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-0-22-001

CERTIFICATE OF BIRTH

S135772

County of Shoshone

City of Wallace

BUREAU

Registration District No. 72

File No.

No. St

Primary Registration District No. 1211

Registered No. 76

Hospital Wallace

FULL NAME OF CHILD William

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u> Number in order of birth <u>1</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>Jan 13</u> 191 <u>5</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

FULL NAME FATHER <u>James Ryan</u>
RESIDENCE <u>Burke</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Oklahoma</u>
OCCUPATION <u>miner</u>

FULL MAIDEN NAME MOTHER <u>Leona Otto</u>
RESIDENCE <u>Burke</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>North Dakota</u>
OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth..... Number of children of this mother now living, including present birth.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was William at 7 A.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. L. Smith

(Physician or midwife)

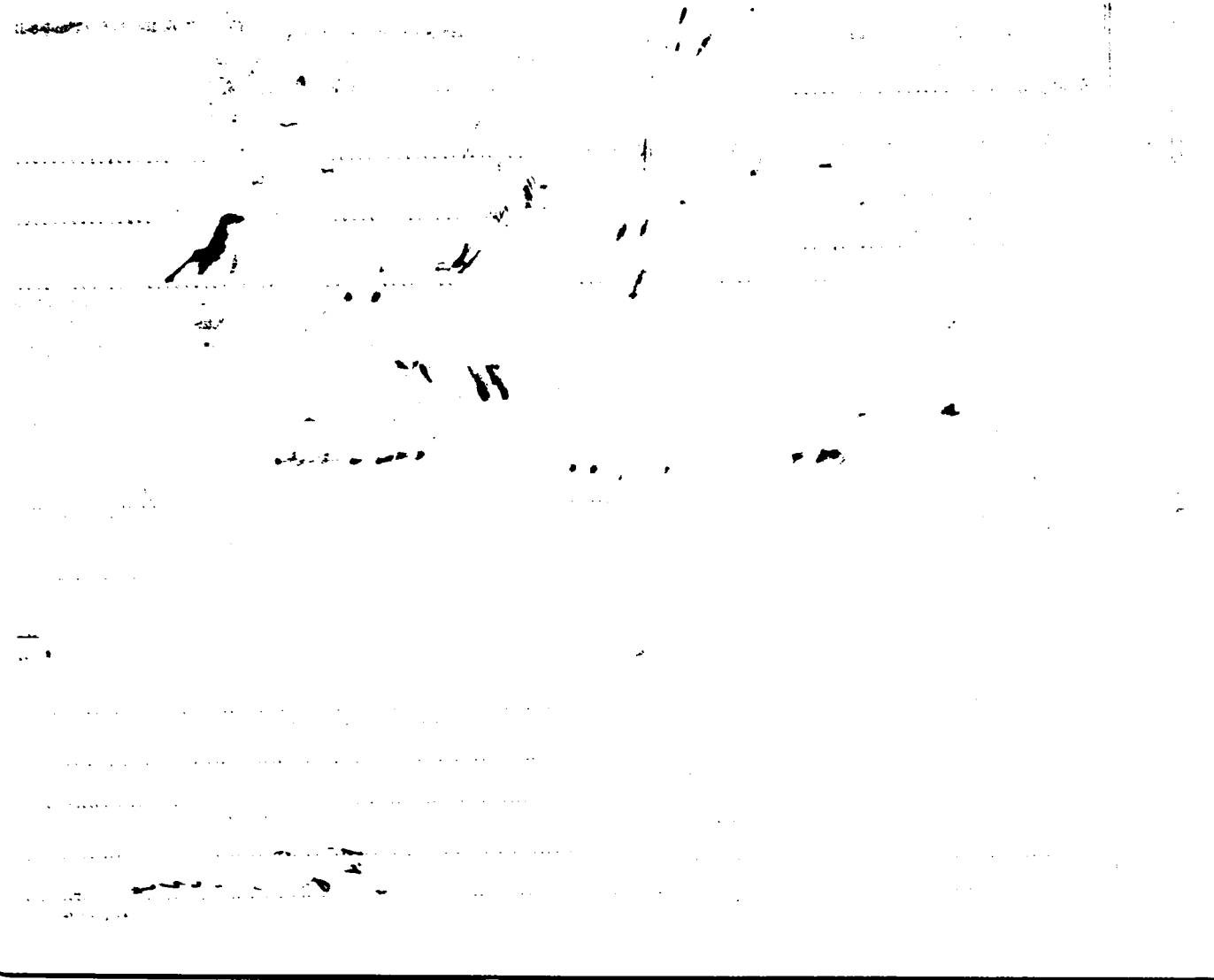
Given names added from a supplemental report.

Address.....

Filed Aug 11 1925

Registrar

Registrar



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Shoshone* Registration District No. *70*

City of *Wallace* Primary Registration District No. *1911*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Son of Jas. Ryan

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *50079*

Local Registrar's No. *7*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

single
(Write the word)

6. DATE OF BIRTH

Jan 13

1925

(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

James Ryan

11. BIRTHPLACE

OF FATHER

(State or Country)

Oklahoma

12. MAIDEN NAME

OF MOTHER

Lena Otto

13. BIRTHPLACE

OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Ryan
Wallace Idaho

15.

Filed

Jan 16

1925

F L Dunder

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

13

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
19 to 19

that I last saw him alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born child

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ward T. Smith

(Address) *Wallace Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or

usual residence

none

19. PLACE OF BURIAL OR REMOVAL

Wallace Ida

DATE OF BURIAL

Jan 16 1925

20. UNDERTAKER

Ward Und. Co.

ADDRESS

Wallace Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

THIS IS A PERMANENT RECORD

WRITE PLAINLY WITH UNFADING INK

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

419-216-000-000
PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. & No. 11-C-22a-4-27

County of Shoshone

RECEIVED

City of Wallace

OCT 31 1925

S135818

No. 52

BUREAU OF VITAL STATISTICS

File No.

Hospital Wallace

Primary Registration District No. 1011

Registered No. 82

FULL NAME OF CHILD Still born

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u> and <u> </u> Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>Oct 16</u> 192 <u>5</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

FATHER	
FULL NAME <u>Robert Marshall</u>	
RESIDENCE <u>Wallace</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u> </u> (Years)
BIRTHPLACE <u> </u>	
OCCUPATION <u> </u>	

MOTHER	
FULL MAIDEN NAME <u> </u>	
RESIDENCE <u>Wallace</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u> </u> (Years)
BIRTHPLACE <u> </u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still born at 11:57 P. M. on the date above stated. (Born alive or still born)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. T. Smith

(Physician or midwife)

Given names added from a supplemental report.

Address
Filed Oct 17 1925
Registrar J. L. Jensen

PLACE OF BIRTH

STATE OF OHIO
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF HEALTH

County of

City of

No.

DATE OF BIRTH

Sex

Color

Height

Weight

Build

Complexion

Education

Occupation

Marital Status

Religion

Place of Birth

Parents' Names

Signature

Date

Witness

Signature

Date

Signature

Signature

Date

Signature

Date

Signature

Date

Signature

Signature

Date

Signature

Date

DEPARTMENT OF HEALTH

Signature

Signature

Signature

Date

Signature

Date

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

JUL 2 1925
Registration District No. 70

County of Shoshone

BUREAU OF VITAL STATISTICS
Registration District No. 1011
Wallace Hospital St.

City of Wallace

State File No. 50110

Local Registrar's No. 23

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Daughter of R.A. Marshall

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *f* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *s*
(Write the word)

16. DATE OF DEATH

6. DATE OF BIRTH *Mar. 16 - 1925*
(Month) (Day) (Year)

March 16 19 *25*
(Month) (Day) (Year)

7. AGE *Stillborn* IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw h. alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Still born infant Born 11:30 P.M.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

(Duration) yrs. mos. ds.

Contributory (Secondary)

9. BIRTHPLACE (State or Country) *Idaho*

(Duration) yrs. mos. ds.

10. NAME OF Father *R.A. Marshall*

(Signed) *Max T. Smyth* M. D.

11. BIRTHPLACE OF FATHER (State or Country) *Wisconsin*

(Address) *Wallace*

12. MAIDEN NAME OF MOTHER *Melissa Page*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER (State or Country) *Minnesota*

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place In the of death yrs. mos. days. State yrs. mos. ds.

(Informant) *R.A. Marshall*

Where was disease contracted if not at place of death?

(Address) *Wallace, Idaho*

Former or usual residence

15. *F L Dwyer*

19. PLACE OF BURIAL OR REMOVAL *Wallace Idaho* DATE OF BURIAL *3-17-1925*

Filed *March 17 1925* Local Registrar

20. UNDERTAKER *B. G. Horstall* ADDRESS *Wallace Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

27-16-642-25-1
PLACE OF BIRTH

RECEIVED
NOV 2 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls
City of Twin Falls
No. _____ St. _____
Hospital J. F. Co. Gen. Primary Registration District No. 2085 State File No. _____
Local Registrar's No. _____

135888

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Female Twins Triplet or other? } and { Number in order of birth } Legitimate? yes Date of birth Oct 16 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none (Still Born)

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Clarence E. Stanley</u>	FULL MAIDEN NAME	<u>Myrtle Beaton</u>
RESIDENCE	<u>Shodair Rooms Twin Falls</u>	RESIDENCE	<u>Shodair Rooms Twin Falls</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>28</u> (Years)	AGE AT LAST BIRTHDAY	<u>21</u> (Years)
BIRTHPLACE	<u>Tennessee</u>	BIRTHPLACE	<u>Three Creek, Ida</u>
OCCUPATION	<u>Laborer</u>	OCCUPATION	<u>Hwof.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn 5:25 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Twin Falls, Ida.

Filed Nov 1925 John F. Laughlin Registrar.

Registrar.

THE NATIONAL ARCHIVES

State file No. 40

Administrative Registration District No. 1, Local Registration

FILE IN NAME OF CHILD.

...to agree that another such : on to one of the

[illegible]

Walt Whitman was not only a poet but also a social reformer.

Number of child at this age per now living, including those born

MOTHER

4187

১৯৮১

३७५५ : ३६५५

SECRET

545.125

DATE AT LAST
YACHTING

92105

304-197477119

БІЛІМ

NOT AVALUATED

COOPERATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

to my recollection that I attended the birth of this child who was a girl.

[illegible]

548

7. *Extending*

As the number of firms in the industry grows, the number of firms that are able to produce at the minimum average cost also grows. In the long run, the number of firms in the industry will grow until the number of firms is large enough to produce at the minimum average cost. In the long run, the number of firms in the industry will grow until the number of firms is large enough to produce at the minimum average cost.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 3-A-25M. 1-19.

1. PLACE OF DEATH

County of *Lincoln* State of *Idaho* Registration District No. *37*
City of *Idaho Falls* (No. *11*) *Idaho Falls Hospital* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Betty Stanley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *51224*

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH

Oct. 16 1922
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

C. E. Stanley

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Myrtle Beaton

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. E. Stanley
Idaho Falls

15.

Filed *Nov*

1925 John I. Brough
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 16 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *10-16 1925* to *10-16 1925*

that I last saw him *at home* on *10-16 1925*

and that death occurred on the date stated above, at *Idaho Falls*.

The CAUSE OF DEATH* was as follows:

Placenta (partial placenta previa)
(7 3/4 mo. gestation)
(Duration) ~ yrs. ~ mos. ~ ds.

Contributory (Secondary)

Not known cause

(Duration) ~ yrs. ~ mos. ~ ds.

(Signed)

C. E. Stanley

M. D.

10-16 1925 (Address) *Idaho Falls Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

Sept 17 1925

20. UNDERTAKER

ADDRESS

J. J. Fromman Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

292-122-044-632
PLACE OF BIRTH
County of Washington
City of Mesa
No. _____ St. _____ Registration District No. 86 State File No. _____
Hospital _____ Primary Registration District No. 2112 Local Registrar's No. 21
FULL NAME OF CHILD Jesse Joe Kiser

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

135924

(Certificate of no value without full name of child)
Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legiti- mate? Yes Date of birth Aug 22nd 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Born oint Salubon

Number of child of this mother, including present birth Two Number of child of this mother now living, including present birth Two

FATHER		MOTHER	
FULL NAME	<u>William Kiser</u>	FULL MAIDEN NAME	<u>Ayko Olson</u>
RESIDENCE	<u>Mesa Idh R. 4, D. 4</u>	RESIDENCE	<u>Mesa Idh</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>43</u> (Years)	AGE AT LAST BIRTHDAY	<u>28</u> (Years)
BIRTHPLACE	<u>New Mex-co</u>	BIRTHPLACE	<u>Sweden</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 9 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) W. M. Kiser
Father
(Physician or midwife)

Address _____
Filed Sept 1st 1925 W. R. Hamblin
Registrar. Registrar.

PERSONAL AND CONFIDENTIAL - THIS CERTIFICATE IS NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS DESIGNED. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM. ANY VIOLATION OF THIS NOTICE IS SUBJECT TO PROSECUTION.

COUNTY OF _____
 CITY OF _____
 No. _____
 Registration District No. _____
 Primary Registration District No. _____
 Local Registrar's No. _____
 Hospital _____
 FULL NAME OF CHILD _____
 (Certificate of no value without full name of child)
 Sex of Child _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____
 (To be answered only in case of a stillbirth)
 Weight _____
 Length _____
 Head _____
 Chest _____
 Arm _____
 Leg _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____
 (To be answered only in case of a stillbirth)
 Weight _____
 Length _____
 Head _____
 Chest _____
 Arm _____
 Leg _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____
 (To be answered only in case of a stillbirth)

What obstetrical solution was used in case of _____
 Number of child of this mother, including present birth _____
 Number of child of this mother now living, including present birth _____
 FATHER
 FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____
 MOTHER
 FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____ at _____
 (Physician or Midwife)
 (Signature)
 (Address)
 (Date)
 (Hospital)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

712-242-245
PLACE OF BIRTH

RECEIVED
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
NOV 12 1925
BUREAU OF VITAL STATISTICS

S

County of Bear Lake
City of Lamar
No. _____ St. _____ Registration District No. 6-3 State File No. 311
Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ and { Number in order of birth _____ } Legiti- Yes Date of birth Oct 12 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Clarence Passey
RESIDENCE Lamar Idaho
COLOR White AGE AT LAST BIRTHDAY 35
(Years)
BIRTHPLACE Wingate Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Maomi Francis Bunn
RESIDENCE Lamar, Idaho
COLOR White AGE AT LAST BIRTHDAY 32
(Years)
BIRTHPLACE Lamar Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born—alive } at 9:10 P M.
on the date above stated. { Stillborn } at _____

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) W. J. Schmitt
Physician
(Physician or midwife)
Address Lamar, Idaho
Filed 11-3 1925 Mary J. Schmitt
Registrar.

I hereby certify that I am a duly qualified and
 licensed physician and surgeon in the State of
 New York, and that I am duly qualified to
 perform the duties of a physician and surgeon.

I hereby certify that I am a duly qualified and
 licensed physician and surgeon in the State of
 New York, and that I am duly qualified to
 perform the duties of a physician and surgeon.

COUNTY OF _____ CITY OF _____
 STATE OF _____
 PRIMARY REGISTRATION DISTRICT NO. _____
 LOCAL REGISTRAR'S NO. _____
 HOSPITAL _____
FILL IN NAME OF CHILD
 Certificate of no value without full name of child
 (Name) (Last) (First) (Middle)
 (Date of Birth) (Month) (Day) (Year)
 (Sex) (Male) (Female)
 (Color) (Caucasian) (Negro) (Other)
 (Age at last birthday) (Years)
 (Occupation)
 (Date of last examination) (Month) (Day) (Year)
 (Signature of Physician)
 (Signature of Registrar)
 (Signature of Hospital)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

962-225-010-499

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonanza RECEIVED
City of Idaho Falls, Ida NOV 20 1925
No. 73 St. BUREAU OF VITAL STATISTICS No. 73 State File No. 136245
Hospital L.D.L. Primary Registration District No. 2100 Local Registrar's No. 314-
FULL NAME OF CHILD Rose Baby

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? } and { Number in order of birth } Legitimate? yes Date of birth 9-25-1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Rose, Alfred J.
RESIDENCE Idaho Falls, Ida
COLOR white AGE AT LAST BIRTHDAY 46 (Years)
BIRTHPLACE Bethesda, Ill.
OCCUPATION Carpenter

MOTHER
FULL MAIDEN NAME Wright, Sarah
RESIDENCE Same
COLOR white AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4:58 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) W. R. Hatcher
(Physician or midwife)

Address Idaho Falls
Filed Oct 3 1925 1-1 Registrar.

Registrar.

Registrar.

2

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____
Hospital _____
Primary Registration District No. _____
Local Registrar's No. _____

FULL NAME OF CHILD

(Certificate of no name without full name of child)

Sex of _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Month _____
Year _____
Legal Name _____
Sex of _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Month _____
Year _____
Legal Name _____

What pathological condition was used in event?

Number of child of this mother, including present birth _____
Number of child of this father, including present birth _____

MOTHER

FATHER

NAME	RESIDENCE	COLOR	AGE AT LAST BIRTHDAY (Years)	BIRTHPLACE	OCCUPATION
FULL NAME					
MAIDEN NAME					
RESIDENCE					
COLOR					
AGE AT LAST BIRTHDAY (Years)					
BIRTHPLACE					
OCCUPATION					

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

*When there was no attending physician or midwife, then the father, mother, or another adult male, or female, A child is one that is not yet born, and is not yet out of the mother's womb. The name of the child, as a pathological report.

(Signature) _____
(Physician or midwife)

Address _____
Phone _____

THIS CERTIFICATE IS TO BE FILED IN THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF PUBLIC WELFARE, STATE OF IDAHO, AND IN THE COUNTY CLERK'S OFFICE, IN THE COUNTY OF _____, IDAHO.

AD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

236-201-010-143
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonanza NOV 20 1925
City of Idaho Falls IDAHO
STATE OF IDAHO

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 73 State File No. 136256
Hospital Spencer Primary Registration District No. 2100 Local Registrar's No. 304

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes.</u>	Date of birth. <u>Oct 1</u> 192 <u>5</u> (Month) (Day) (Year)
-------------------------------	---	--------------------------------------	---------------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>James Basson Stone</u>	<u>Idaho Falls Idaho</u>	<u>Emma Ault</u>	<u>Idaho Falls Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)
BIRTHPLACE <u>Iowa</u>		BIRTHPLACE <u>Idaho Falls Idaho</u>	
OCCUPATION <u>Salesman</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 5:00 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. J. Spencer

(Physician or midwife)

Address Idaho Falls Idaho

Filed Oct 13 1925

Registrar.

Registrar.

THIS IS A CERTIFICATE OF BIRTH, NOT A DEATH CERTIFICATE. IT IS NOT VALID FOR ANY OTHER PURPOSE. IT IS NOT VALID FOR ANY OTHER PURPOSE. IT IS NOT VALID FOR ANY OTHER PURPOSE.

CERTIFICATE OF BIRTH

City of _____ State of _____

No. _____

Registration District No. _____

Local Registration District No. _____

FULL NAME OF CHILD

Sex of Child

Place of Birth

Month (M) _____ **Day (D)** _____ **Year (Y)** _____

Number of children of this mother, including present birth

Number of children of this mother, including present birth

FATHER

NAME _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY _____

MOTHER

NAME _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY _____

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

_____ (Signature)

_____ (Physician or Midwife)

A three _____

Filed _____

192 _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 2150
(See Idaho Falls St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51367

Local Registrar's No. 114

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

5. DATE OF BIRTH

Oct 1 1925
(Month) (Day) (Year)

6. AGE

Born Dead
Yrs. Mos. ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

no.

9. BIRTHPLACE

(State or Country) Idaho Falls Ida

10. NAME OF FATHER

JOB Stone

11. BIRTHPLACE OF FATHER

(State or Country) Tennessee

12. MAIDEN NAME OF MOTHER

Anna Aust

13. BIRTHPLACE OF MOTHER

(State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

JOB Stone
(Address) Idaho Falls Ida

15.

Filed Oct 3 19 25 W. Spencer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 1 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 19 25 to Oct 1 19 25

that I last saw him alive Oct 1 19 25
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Spencer M. D.

Oct 3 19 25 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls Ida Oct 3 19 25

20. UNDERTAKER

ADDRESS

W. Spencer Idaho Falls Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

251-116-009-393
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

DEC 7 1925

City of Sandpoint

CERTIFICATE OF BIRTH **136302**

No. St. Registration District No. 76 State File No.

Hospital Sandpoint Hospital Primary Registration District No. 2155 Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>October 16, 1925</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1st. Number of child of this mother now living, including present birth None

FATHER
FULL NAME Bert Searfus

RESIDENCE Dover, Idaho.

COLOR White AGE AT LAST BIRTHDAY 33
(Years)

BIRTHPLACE Washington

OCCUPATION Rancher

MOTHER
FULL MAIDEN NAME Gladys Witzel

RESIDENCE Dover, Idaho.

COLOR White AGE AT LAST BIRTHDAY 17
(Years)

BIRTHPLACE South Dakota

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at About 6.30 Pm. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) V. D. Graus

Physician
(Physician or midwife)

Dover, Idaho.

Address

Filed Dec 4 1925

Viola Allen
Deputy Registrar.

Registrar.

CHARTER OF RIGHTS

Registration District No. _____
 County Registration District No. _____ Local Registrar's No. _____

NAME OF CHILD

(Certificate of no name without full name of child)

Sex of _____
 Date of _____
 Birthplace _____
 Occupation _____
 Color _____
 Age at last birthday _____
 Full name _____
 Mother's name _____
 Father's name _____
 Number of child in this family _____
 Number of child in this family _____
 Number of child in this family _____

Number of child in this family _____
 Number of child in this family _____
 Number of child in this family _____

Number of child in this family _____
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Number of child in this family _____
 Number of child in this family _____
 Number of child in this family _____

Number of child in this family _____
 Number of child in this family _____
 Number of child in this family _____

I hereby certify that I attended the birth of this child who was _____
 the date above stated.
 I hereby certify that I attended the birth of this child who was _____
 the date above stated.
 I hereby certify that I attended the birth of this child who was _____
 the date above stated.

CHARTER OF RIGHTS
 I hereby certify that I attended the birth of this child who was _____
 the date above stated.
 I hereby certify that I attended the birth of this child who was _____
 the date above stated.
 I hereby certify that I attended the birth of this child who was _____
 the date above stated.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
NOV 6 1925
CERTIFICATE OF DEATH
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **50997**

PLACE OF DEATH

County of Bonner
City of Landpoint

District No. 7.6
Registration District No. 2155

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME

(a) Residence. No. 1606, Ada

St. _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct. 16 1925

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

Still born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Landpoint, Idaho
(State or country)

PARENTS

10 NAME OF FATHER

Bert Searfuss

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Leaside
Washington

12 MAIDEN NAME OF MOTHER

Stadys Witte

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Antonia
North Dakota

14 Informant

Bert Searfuss
Ada, Idaho

15 Filed

Oct 17, 1925 Viola Allen
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October

16th

19 25
(Year)

(Month)

(Day)

17

I HEREBY CERTIFY, That I attended deceased from

19 ____ to 19 ____

that I last saw him alive on Still Birth 19 ____

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Protracted Uninflamed Card.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? P.B. Examine M. D.

(Signed)

Oct 16, 1925 (Address) Ada, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Pinecrest Cemetery

Oct 17, 1925

20. Undertaker

Address

Ada, Idaho Landpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

913-101014-763

County of CanyonCity of Nampa

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD _____

RECEIVED

DEC 3 1925

BUREAU OF VITAL STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

136354

Registration District No. 7 State File No. _____Primary Registration District No. 1006 Local Registrar's No. 164

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Oct 1st</u> 192 <u>5</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

FULL NAME <u>Percy Geo Ralf</u>	FATHER
RESIDENCE <u>Nampa</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Kansas</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Verda Pollard</u>	MOTHER
RESIDENCE <u>Nampa</u>	
COLOR <u>Wht</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Colorado</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:20 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

CERTIFICATE OF BIRTH

No. _____ Date of Birth _____

Primary Registration District No. _____ Local Registration District No. _____

(Certificate of no value without full name of child)

Full Name of Child _____ Sex _____ Date of Birth _____
 (To be answered only in case of plural birth)

Place of Birth _____
 Name of Mother _____

Full Name of Father _____
 Name of Mother _____

Residence _____

Age at Last Birthday _____

Birthplace _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 (Signature of Physician or Midwife)

Address _____
 (Signature of Physician or Midwife)

When there was no attending physician or midwife, the birth was attended by a layman. A statement of the name of the layman and the date of birth should be made and signed by the layman.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **50698**

PLACE OF DEATH

County of Lanyon Registration District No. 3

City of Hampton Primary Registration District No. 3

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)
(No. 6 1/2 miles N.W. of Hampton)

2. FULL NAME Infant son of Percy Raff

(a) Residence. No. _____ St. _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 1896

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____
(State or country) _____

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) _____

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) _____

14 Informant _____

(Address) _____

15 Filed _____

Oct 2, 1925

Registrar

16 DATE OF DEATH

Oct
(Month)

1
(Day)

1925
(Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

that I last saw h. _____ alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH is as follows:

uterine gestation 7 1/2 mon
stillbirth cause not
in evidence. Was dead when born
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY _____
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Dr. R. Proctor M. D.

Oct 2, 1925 (Address) Hampton

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Shelburne Co.

Oct 1, 1925

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
413-20706962
County of Chand
City of Burley
No. 1 1/2 W. on Highway Registration District No. 117 State File No. 136406
Hospital _____ Primary Registration District No. 2196 Local Registrar's No. 3254
FULL NAME OF CHILD Matson

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? ☒ and { Number in order of birth 1 } Legitimate? yes Date of birth 11-7-1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Silver Nitrate

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Ray Matson
RESIDENCE 1 1/2 W. on Highway
COLOR White AGE AT LAST BIRTHDAY 31
(Years)
BIRTHPLACE Illinois
OCCUPATION Lumber Thinner

MOTHER
FULL MAIDEN NAME Eva Roseborough
RESIDENCE Burley Idaho
COLOR White AGE AT LAST BIRTHDAY 24
(Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn 12 Nov
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. C. C. Johnson

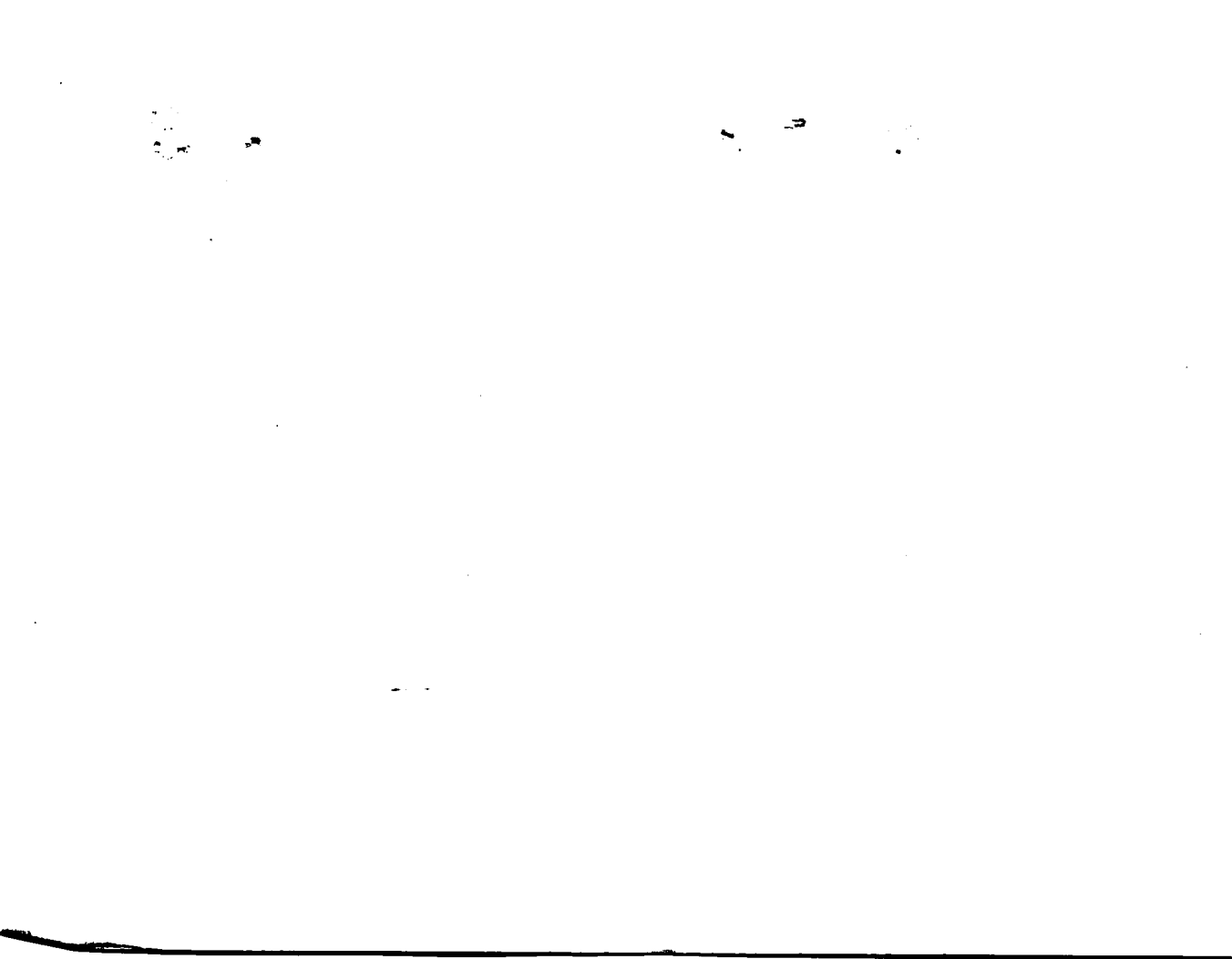
(Physician or midwife)

Address Burley Idaho

Filed 12-1-1925

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Matson

CERTIFICATE OF DEATH

Registration District No. 117

Primary Registration District No. 2196

S.No.

St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51407

Local Registrar's No. 807

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Infant
(Write the word)

6. DATE OF BIRTH

Nov. 7 1925
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant.

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
Father

Ray Matson

11. BIRTHPLACE
OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME
OF MOTHER

Eva Roseborough

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. J. Johnson

(Address)

Burley Idaho

15.

Filed 11-10

1925

Dr. J. C. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 7 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7 1925 to Nov. 7 1925,

that I last saw him alive on Nov. 7 1925, and that death occurred on the date stated above, at 12:30

The CAUSE OF DEATH* was as follows:

Pro lapse of umbilical cord
asphyxia just before delivery
(Duration) yrs. mos. ds.

Contributory
(Secondary)

fluoridates
(Duration) yrs. mos. ds.

(Signed)

Nov. 8 1925

(Address)

E. J. Johnson
Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida

DATE OF BURIAL

Nov. 8 1925

20. UNDERTAKER

D. E. Johnson

ADDRESS

Burley Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

695-118016553
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

S

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DEC 12 1925

CERTIFICATE OF BIRTH 136411

BUREAU OF VITAL
STATISTICS

Registration District No. 117

File No.

County of Cassia

City of Burley

No. St.

Hospital

Primary Registration District No. 2196

Registered No. 3259

FULL NAME OF CHILD

No name

(Certificate of no value without full name of child.)

Sex of
Child

Male

Twin
Triplet
or other?

— and

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

Oct 18

1925
(Month) (Day) (Year)

What bacterioidal solution was used in eyes? Ag. No. 3

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

Claude Woodward

RESIDENCE

Burley

COLOR

White

AGE AT LAST
BIRTHDAY

28

(Years)

BIRTHPLACE

Utah

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Marcus Nelson

RESIDENCE

Burley

COLOR

White

AGE AT LAST
BIRTHDAY

18

(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at 12:30 A. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

F. H. Curtis

(Physician or midwife)

Give names added from a supplemental report.

Address

Burley Ida

Filed

12-1 1925 Dr. J. C. Patterson

Registrar.

Registrar.

2

CH 11

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
144 21014 796		DEPARTMENT OF PUBLIC WELFARE	
County of <u>Cassia</u>		BUREAU OF VITAL STATISTICS	
City of <u>Burley</u>		RECEIVED	
No. _____ St. _____		DEC 12 1925	
Hospital _____		BUREAU OF VITAL STATISTICS	
FULL NAME OF CHILD <u>J. D. Vance</u>		Registration District No. <u>117</u>	
		Primary Registration District No. <u>2196</u>	
		File No. <u>136415</u>	
		Registered No. <u>3263</u>	
(Certificate of no value without full name of child.)			
Sex of Child <u>Male</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>1/21/25</u> 1925
	(To be answered only in event of plural births)		(Month) (Day) (Year)
What bactericidal solution was used in eyes? <u>Ag. 2603</u>			
Number of child of this mother, including present birth <u>3</u>		Number of child of this mother now living, including present birth <u>3</u>	
FULL NAME <u>L. F. Judd</u>	FATHER	FULL MAIDEN NAME <u>Pearl Groseman</u>	MOTHER
RESIDENCE <u>Burley</u>		RESIDENCE <u>Burley</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Mich.</u>		BIRTHPLACE <u>Mich.</u>	
OCCUPATION <u>Lawyer</u>		OCCUPATION <u>Housewife</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
I hereby certify that I attended the birth of this child, who was <u>Born alive</u> at <u>6 40 A.</u> M. on the date above stated. (Born alive or stillborn)			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.			
(Signature) <u>F. H. Crater</u> M.D.			
(Physician or midwife)			
Give names added from a supplemental report.			
Address <u>Burley Ida</u>			
Filed <u>12-1</u> 192 <u>5</u> <u>Dr. J. C. Patterson</u>			
Registrar.			

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
JAN 11 1964

NO D

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

381 126 027-268
PLACE OF BIRTH

RECEIVED

NOV 13 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

136618

County of Jerome

City of Jerome

No. _____ St. _____

Hospital Home

BUREAU OF VITAL
STATISTICS

Registration District No. 23

File No. _____

Primary Registration District No. 2017

Registered No. 27

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other (To be answered only in event of plural births)	and	Number in order of birth <u>1st</u>	Legiti- mate? <u>yes</u>	Date of birth <u>8/26</u> 192 <u>5</u> (Month) (Day) (Year)
-----------------------	--	-----	--	-----------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth. 1st Number of child of this mother now living, including present birth. 0

FATHER
FULL NAME Herbert O. Chandler
RESIDENCE Jerome Ida
COLOR W AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Mo
OCCUPATION Farmer

MOTHER
FULL NAME Edna May Boyd
RESIDENCE Jerome Ida
COLOR W AGE AT LAST BIRTHDAY 18 (Years)
BIRTHPLACE Ida
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 2 a. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. F. Zeller
M.D.
(Physician or midwife)

Give names added from a supplemental report.

Address Jerome Ida
Filed 11-10 1925 E. C. Barry Registrar.

Registrar.

JAN 6 1964

NO D

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

413-124-029-364
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

136687

S

County of Latah DEC 5 1925

City of Tray, Idaho BUREAU OF VITAL STATISTICS

No. _____ St. Registration District No. 64 State File No. _____

Hospital _____ Primary Registration District No. 2144 Local Registrar's No. _____

FULL NAME OF CHILD Albert Merrill Dalberg
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? yes Date of birth Nov. 24 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? No (2 wifes)

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 6

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Lewis P. Dalberg</u>	<u>Tray, Ida.</u>	<u>Ida Caroline Tompson</u>	<u>Tray, Ida.</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Appelbo Sweden</u>		BIRTHPLACE <u>Marion, Maine</u>	
OCCUPATION <u>Butcher</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3 9 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
Nov 30 1925
Lucy M. Pickard Registrar.
(Signature) J. W. Faulkner Physician
(Physician)
Address Tray, Idaho.
Filed Nov. 30, 1925 Lucy M. Pickard Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Idaho*City of *Tray, Ida*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Albert & Merrell Dalberg*RECEIVED
CERTIFICATE OF DEATHRegistration District No. *64*BUREAU OF VITAL STATISTICS
Registration District No. *2144*(No. *2144* St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. *51492*

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word)

6. DATE OF BIRTH

Nov. 24 19*25*
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tray, Idaho

10. NAME OF

Father

Lewis P. Dalberg

11. BIRTHPLACE

OF FATHER

(State or Country)

Appelby, Sweden

12. MAIDEN NAME

OF MOTHER

Ida Caroline Thompson

13. BIRTHPLACE

OF MOTHER

(State or Country)

Morris, Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lewis P. Dalberg

(Address)

Tray, Idaho

15.

Filed

*Nov 30*19*25**Lucy M. Pickard*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 24 19*25*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 24 19*25* to *Nov. 24* 19*25*that I last saw him *stillborn* 19*25*,and that death occurred on the date stated above, at *3 P. M.*

The CAUSE OF DEATH* was as follows:

*Premature Birth**Pl. At*

(Duration) yrs. mos. ds.

Contributory
(Secondary)*Placental Abruption*

(Duration) yrs. mos. ds.

(Signed)

*J. W. Faulkner, M. D.*19*25* (Address) *Tray, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cemetery near Tracy**Nov 24* 19*25*

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

315-208032-243
PLACE OF BIRTH

RECEIVED

NOV 12 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Laramie

City of Shoshone

No. 1016 St. 1016

Hospital See

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

136713

Registration District No. 1016

State File No. 40

Primary Registration District No. 1016

Local Registrar's No. 40

FULL NAME OF CHILD Baby

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>11-8-1925</u> (Month) (Day) (Year)
----------------------------	-----------------------------------	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? See

Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>2</u>	
FULL NAME <u>Leola E. Gunn</u>	FATHER	FULL MAIDEN NAME <u>Viola E. Gunn</u>	MOTHER
RESIDENCE <u>Shoshone</u>		RESIDENCE <u>Shoshone</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Domestic</u>		OCCUPATION <u>Wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 115 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]

(Physician or midwife)

Give names added from a supplemental report.

Address See
Filed Nov 9 1925
Registrar. [Signature]

GEORGE W. LAMAR, JR., A SIFT - THE ORIGINAL WITH NO OTHER ATTACH
 not shown of name of child and date of birth. No other to be taken at
 birth.

COUNTY OF _____
 CITY OF _____
 No. _____
 Hospital _____
 Primary Registration District No. _____
 Local Registration No. _____
 State File No. _____
CERTIFICATE OF BIRTH
 DEPT. OF HEALTH
 BUREAU OF VITAL STATISTICS

FULL NAME OF CHILD _____
 Sex of Child _____
 Date of Birth _____
 Date of Birth (Month) _____
 Date of Birth (Year) _____
 (To be answered only in event of legal date)

Number of child of this mother, including present birth _____
 Number of child of this mother now living, including present birth _____
 FATHER
 FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY (Years) _____
 BIRTHPLACE _____
 OCCUPATION _____
 MOTHER
 FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY (Years) _____
 BIRTHPLACE _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____
 at _____
 on the _____ above named.
 (Signature) _____
 (Physician or midwife)
 Give name of child and date of birth in report _____
 (Physician or midwife)

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of *Lincoln*City of *Shoshone*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

NOV 12 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No. *1016*

51505

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *18*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Nov 8 1925

(Month)

(Day)

(Year)

7. AGE

*Still Born*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Shoshone Idaho

10. NAME OF FATHER

Lester B Cannon

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

Wilbur Buller

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester B Cannon

(Address)

Filed *Nov 9 1925**1925**J. L. Fuller*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 8 1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 7 1925 to *Nov 8 1925*that I last saw him alive on *Nov 7 1925*and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

*Dead in Utero.
Macrosomatism*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)*Conjunctivitis*

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Nov 9 1925

(Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone *Nov 9 1925*

20. UNDERTAKER

ADDRESS

J. L. Fuller

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

962-112033-241

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

NOV 16 1925

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 36736

County of Madison

City of Rexburg

No. 70-E-4411 St.

Registration District No. 100

State File No. 100

Hospital Emergency

Primary Registration District No. 2178

Local Registrar's No. 1249

FULL NAME OF CHILD none - stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>9-12-1925</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes 2% Mercurochrome. none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Edward J. Robertson
RESIDENCE Rexburg
COLOR White AGE AT LAST BIRTHDAY 50 (Years)
BIRTHPLACE Wisconsin
OCCUPATION R.R. Contractor

MOTHER
FULL MAIDEN NAME Margaret Smalley
RESIDENCE Rexburg
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Missouri
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) John A. Rich

(Physician or midwife)

Address Rexburg, Idaho

Filed 11/9 1925

Registrar.

Registrar.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 100
BUREAU OF VITAL STATISTICS
(STATISTICS) St.Redd STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51145

Local Registrar's No. 247

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 Sept 10 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1925 to Sept 12 1925, that I last saw him alive on Sept 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stiebsom
macrolia forus
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Loring Stiebsom M. D.
1925 (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

365 214-035-455
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. S. No. 11-C-25m-9-8-15

BUREAU OF VITAL STATISTICS

NOV 12 1925

BUREAU OF VITAL

CERTIFICATE OF BIRTH

136810

S

County of NezperceCity of LewistonNo. 4th & Main St.Registration District No. 96File No. 1Primary Registration District No. 1009Registered No. 1Hospital _____FULL NAME OF CHILD Mary GoreSex of Child F.Twin
Triplet
or other?{ and } Number
in order
of birthLegiti-
mate? yes.Date of
Birth 10-14-1925

(Month) (Day) (Year)

FULL
NAME

FATHER

Gregory Gore

RESIDENCE

Lewiston

COLOR

whiteAGE AT LAST
BIRTHDAY 31

(Years)

BIRTHPLACE

Italy

OCCUPATION

ShoemakerFULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

W.AGE AT LAST
BIRTHDAY 27

(Years)

BIRTHPLACE

Italy

OCCUPATION

Home wifeNumber of child of this mother, including present birth 5Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

(Born alive or stillborn)

at 10:30 A. M.{ *When there was no attending physician or
midwife, then the father, householder, etc., should
make this return. A stillborn child is one that
neither breathes nor shows other evidence of life
after birth. }

(Signature)

W. F. Mc Mahan

(Physician or midwife)

Given names added from a supplemental report.

Address

Lewiston Idaho.

Filed

Nov 7 1925 Susan E Bruce

Registrar

capitula

(continued)

...and the fact that the ...

at the time of the investigation, the subject was not known to be in contact with the subject.

divid. income, including net long-term capital gain, is not taxable.

at the time of the investigation, the subject was not known to be in contact with the subject.

ИЗДАНИЕ

81-19479-18

FOR

RECEIVED

MEMPHIS

taken at 1000
 depth is 1000
 (depth is 1000)

100-443881-1

100-443881-1

[illegible]

100

10. 4/10/10

PLATE 19

CHAS. E. INTZ
BOITSTATE / VOLAERUS

21-8-2-CONF-7-15-12-2-V-1000

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of NesPerce.City of Lewiston.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

NOV 12 1925

BUREAU OF STATISTICS

2. FULL NAME Stillborn Lore.Registration District No. 96Primary Registration District No. 1009

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 51546

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

October

(Month)

14th

(Day)

1925

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Stillborn.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Gregory Lore.

11. BIRTHPLACE OF FATHER

(State or Country)

Italy.

12. MAIDEN NAME OF MOTHER

Mary Anna Muzze.

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lewiston, Idaho.

15.

Filed

Nov 9 1925James E. Hume

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1925
(Year)17. I HEREBY CERTIFY, That I attended deceased from 10-14-1925 to same 1925that I last saw her not alive 1925 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cord preceded head. (no movements felt in last two days before birth.)

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

W. J. Mahan M. D.10-14-1925 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

In the

Yrs.

mos.

days.

State

Yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho.

DATE OF BURIAL

10/14 1925.

20. UNDERTAKER

Brower-Wann Company.

ADDRESS

Lewiston, Idaho.

2160

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.*; *Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of OneidaCity of MaladNo. 866-219 036 165BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

136836

St. 866-219 036 165Registration District No. 26

State File No.

Hospital

Primary Registration District No. 2069Local Registrar's No. 164

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Nov 19 1923</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1Number of child of this mother now living, including present birth 0

FULL NAME

FATHER

William Howard

RESIDENCE

Malad

COLOR

White

AGE AT LAST BIRTHDAY

25

(Years)

BIRTHPLACE

Bountiful, ut.

OCCUPATION

Farmer

FULL MAIDEN NAME

MOTHER

Mildred Jones

RESIDENCE

Malad

COLOR

White

AGE AT LAST BIRTHDAY

21

(Years)

BIRTHPLACE

Cherry Creek Ida.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 2:30 P. M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

[Signature]

(Physician or midwife)

Address

MaladFiled 11-301923J. M. Kerns

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

showed clear evidence of life after birth.

It was found that neither breathing nor any sound were retained. A stillborn child was taken from the mother, deceased, by the father, deceased, who was no attending physician.

I hereby certify that I attended the birth of _____ on the _____ above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

OCCLUSION

304-227818

COLO.

MAJ T A 30A

25102.5 (23.9)

REBUTTAL

2014

외국인투자제한

2204

MOTHER

Free and bound new nucleoside triphosphates and NTP

(continued from page 10)

10. x42

7-10-1944

Index

to read

CHILD TO BEAR JURY

(Certificate of no value without full name of child)

Endnotes

Primary Registration District No.

Registration Number No. State File No.

DECLASSIFICATION OF RECORDS

SECRET

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

419 114 038 795
County of Payette.
City of Payette.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED
DEC 1 1925
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

136849

No. District No. 4 State File No.

Hospital Primary Registration District No. 1008 Local Registrar's No. 48

FULL NAME OF CHILD

Glenn Nicholas Marx

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? } and { Number in order of birth Legitimate? Yes. Date of birth Oct. 14 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Harvey Otis Marx.

MOTHER
FULL MAIDEN NAME Pearl Lila Pinkston.

RESIDENCE Dimond, Oregon.

RESIDENCE Diamond, Oregon

COLOR White AGE AT LAST BIRTHDAY 25
(Years)

COLOR White AGE AT LAST BIRTHDAY 18
(Years)

BIRTHPLACE Dufur, Oregon.

BIRTHPLACE Nyssa, Oregon

OCCUPATION Farmer

OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } Stillborn { at 10.30 A. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

J. E. Woodward, M.D.
Physician.
(Physician or midwife)

Address Payette, Idaho.

Filed 10/17/25 1925

Registrar.

Registrar.

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

CHIEF

NAME

RESIDENCE

COLOR

DATE OF BIRTH

EDUCATION

Any other copies of this material have been received by the following:

BATHING

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

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DATE OF BIRTH

DATE OF BIRTH

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

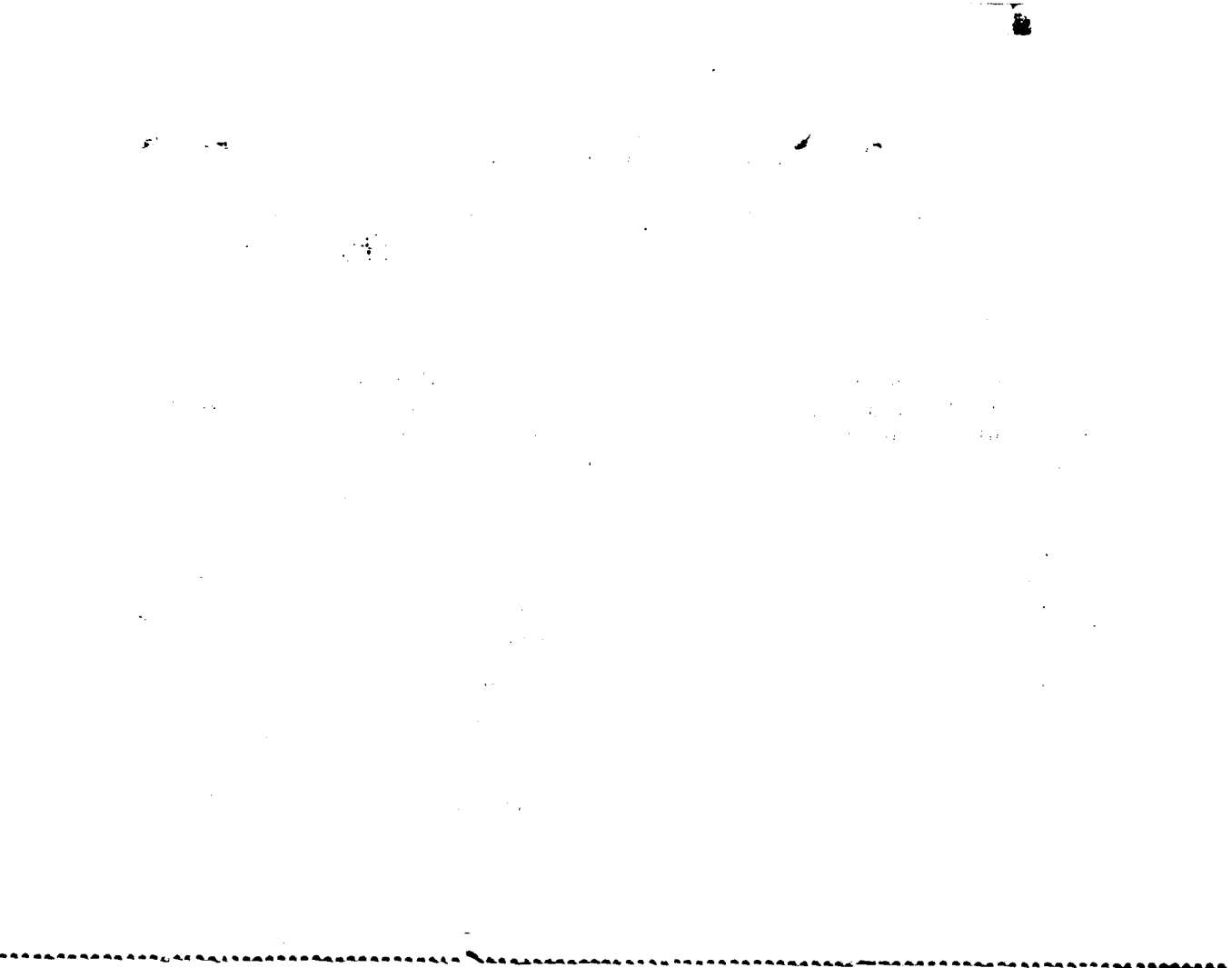
BUREAU OF VITAL STATISTICS

Place of Birth	CITY	<u>Payette</u>	FILE NO.	<u>136849</u>
	ST.	<u>12th</u>	DATE OF BIRTH	<u>Oct. 14, 1925</u>
	COUNTY	<u>Payette</u>	SEX OF CHILD	<u>boy</u>
	FATHER	<u>Harvey Marx</u>	MOTHER	<u>Pearl Pinkston</u> (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Glenn Nicholas Marx

Pearl Marx
Signature of Father or Mother.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Payette
City of Payette

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Marx

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white

(Write the word)

6. DATE OF BIRTH

Oct 14 1925
(Month) (Day) (Year)

7. AGE

Fullborn
0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Payette

10. NAME OF FATHER

Harvey Marx

11. BIRTHPLACE OF FATHER

(State or Country)

Deer Creek

12. MAIDEN NAME OF MOTHER

Clara Pinkston

13. BIRTHPLACE OF MOTHER

(State or Country)

Nyssa Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harvey Marx

(Address)

15.

Filed

Oct 15

19

25 Woodward

Local Registrar

RECEIVED CERTIFICATE OF DEATH

DECEASED 1925 District No. 4
BUREAU OF VITAL STATISTICS
(No. 1008 St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51565BLocal Registrar's No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

Oct 14 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/15/1925 (Address) Payette

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Riverside Cemetery 19

20. UNDERTAKER

ADDRESS

C.R. Augustus Payette

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

995-118042-295
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls RECEIVED
City of Twin Falls DEC 3 1925 BUREAU OF VITAL STATISTICS
No. _____ St. Registration District No. 37 State File No. 136922
Hospital T. J. Higgins Primary Registration District No. 2085 Local Registrar's No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Nov 16th - 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Henry Irvin
RESIDENCE Rogerson, Idaho
COLOR White AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Anaconda, Mont
OCCUPATION Accountant

MOTHER
FULL MAIDEN NAME Beatrice Marie Birney
RESIDENCE Rogerson, Idaho
COLOR White AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Butte, Mont
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:40 A. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) S. H. Alexander

(Physician or midwife)

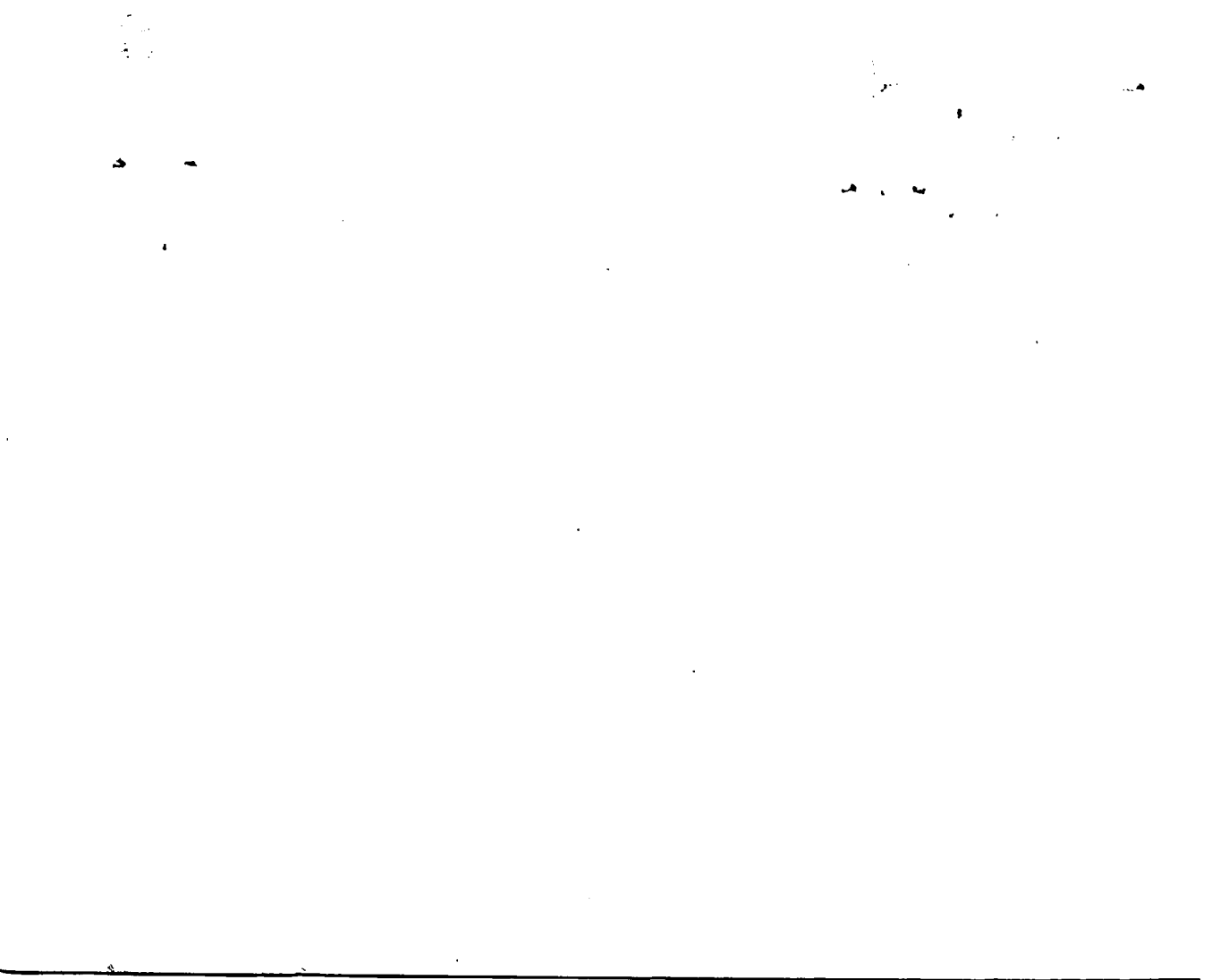
Address Twin Falls, Ida

Filed Dec

1925

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED** **CERTIFICATE OF DEATH**
County of *Lincoln* Registration District No. *37*
City of *Lincoln* Registration District No. *2085*
If death occurs away from usual residence, give facts called for under special information. **BUREAU OF VITAL STATISTICS** *Hospital* St.)
2. FULL NAME *Baby Irwin*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. **51578**
Local Registrar's No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
6. DATE OF BIRTH *Nov 16 1925*
(Month) (Day) (Year)

7. AGE *0* Yrs. *0* Mos. *0* ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION *Infant*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER *Henry Irwin*

11. BIRTHPLACE OF FATHER *Montana*
(State or Country)

12. MAIDEN NAME OF MOTHER *Beatrice Binrose*

13. BIRTHPLACE OF MOTHER *Montana*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Henry Irwin*
(Address) *Regidson Idaho*

15. Filed *Dec 3 1925* *John F. Houghlin* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Nov 16 1925*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *11/16/25* to *11/16/25*
that I last saw ~~he~~ *her* alive on *1925*
and that death occurred on the date stated above, at *4:35 P.M.*
The CAUSE OF DEATH* was as follows:

Still born
(Duration) yrs. mos. ds.
Contributory *umbilical cord around neck*
(Secondary)
(Duration) yrs. mos. ds.
(Signed) *Bureau L. H. H. M. D.*
7/16 1925 (Address) *Irwin Falls Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL *Irwin Falls* DATE OF BURIAL *11/16 1925*
20. UNDERTAKER *POWELL* ADDRESS *Irwin Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

355-102-001-415
PLACE OF BIRTH

STATE OF IDAHO
RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

136965

County of Ada JAN 7 1
City of Boise BUREAU OF VITAL STATISTICS
No. 317 Gron St. Registration District No. File No.
Hospital Primary Registration District No. Registered No. 152
FULL NAME OF CHILD And Leon
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>-</u> and { Number in order of birth <u>-</u> }	Legitimate? <u>yes</u>	Date of birth <u>Dec 2nd 1925</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? none - still birth

Number of child of this mother, including present birth 4th Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>John R. Feem</u>	FULL MAIDEN NAME	<u>Mary Ellen Davis</u>
RESIDENCE	<u>317 Gron St.</u>	RESIDENCE	<u>317 Gron St.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>33</u> (Years)	AGE AT LAST BIRTHDAY	<u>28</u> (Years)
BIRTHPLACE	<u>Colorado</u>	BIRTHPLACE	<u>Nebraska</u>
OCCUPATION	<u>Mechanic</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:20 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. Taylor

(Physician or midwife)

Give names added from a supplemental report.

Address Boise, Idaho

Filed 12-8 1925

Registrar.

Registrar.

2

1875

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JAN 3 1925
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **51595**

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 1004

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Borned Baby Teen

(a) Residence. No. 317 Grove St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Still Born Years Months Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boise Ida (State or country)

10 NAME OF FATHER John R. Teen

11 BIRTHPLACE OF FATHER (city or town) Col. (State or country)

12 MAIDEN NAME OF MOTHER Maria A. Davis

13 BIRTHPLACE OF MOTHER (city or town) Nebr (State or country)

14 Informant John Teen (Address) 317 Grove St

15 Filled 12-3-25 R. W. Pratt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 2 1925 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1925, to Dec 2, 1925, that I last saw him alive on Still Born, 1925, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows: Probably due to Inflammation of Mother 3 weeks ago Fetus Mummified (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) E. M. Taylor M. D. 12/2, 1925 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Maria Hill Date of Burial Dec 3 1925

20. Undertaker Schreiber & Davis Address Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

415 106 003 312

County of Bannock,

City of Near Pocatello

No. R # 1 St. Registration District No. 28 State File No. 73/3

Hospital _____ Primary Registration District No. 2161 Local Registrar's No. 73/3

FULL NAME OF CHILD Stillborn.

(Certificate of no value without full name of child)

Sex of Child	Male.	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Yes.	Date of birth	Nov. 6.	1925
							(Month)	(Day)	(Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER

FULL
NAME

Masaji Maeda.

RESIDENCE

R # 1

COLOR

Brown.

AGE AT LAST

BIRTHDAY

40

(Years)

BIRTHPLACE

Yamini Japan.

OCCUPATION

Farmer.

MOTHER

FULL
MAIDEN
NAME

Matnyo Takisagawa.

RESIDENCE

R # 1

COLOR

Brown.

AGE AT LAST

BIRTHDAY

29

(Years)

BIRTHPLACE

Japan.

OCCUPATION

Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

*Babe born with cord about neck
No one present to care for it - dead Born alive
I hereby certify that I attended the birth of this child, who was Stillborn at 6 A. M.
on the date above stated. Dead when doctor called.*

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. J. Howard, M.D.

(Physician or midwife)

Address

Pocatello, Idaho.

Filed

12/1 1925

Registrar.

Registrar.

RECEIVED
DEC 16 1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

137044

6

11

12

13

14

15

16

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 161
(No. 3 1/2 miles N. of City)

State File No. 51629
Local Registrar's No. 4696

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Masao Maeda

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male Japanese Single

6. DATE OF BIRTH

Nov 6 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many hrs. or min.?
Still born

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Bannock County

10. NAME OF FATHER

Masaji Maeda

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. NAME OF MOTHER

Matsugoto Takusogawa

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Masao Maeda
(Address) R.R. 1, Pocatello

15.

Filed

Nov 6 1925

J.R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

Nov 6 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 Nov 6 1925
that I last saw him alive on Still born 19 Nov 6 1925

and that death occurred on the date stated above, at 12:15 M.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis
Born without doctor or nurse
Cord twice about neck, delayed
birth of body. (Duration) 1 yrs. 0 mos. 0 ds.
Nurse and doctor

Contributory

(Secondary)

Doctor and nurse called after death of child.
(Duration) 1 yrs. 0 mos. 0 ds.

(Signed)

J.R. Young M. D.
11/6/1925 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days State yrs. mos. ds.
Where was disease contracted Still born
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cem Pocatello Nov 6 1925

20. UNDERTAKER

ADDRESS

McIntyre and Co. Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

289 * 24 003 844
PLACE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH
County of Danmark

City of Pacatillo

No. 21 St.

Hospital St. Anthony

FULL NAME OF CHILD.....

(Certificate of no value without full name of child)

Sex of Child	Male	Twin Triplet or other?	1
--------------	------	------------------------	---

Twin Triplet or other?

1

$$\} \text{ and } \{$$

**Number
in order
of birth**

Legitimate?

yes.

Date of birth.....

Nov.

24

1923

What bactericidal solution was used in eyes?

~~Silver Nitrate 1% Isp. error~~

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth.

FULL NAME *P* **FATHER**

FATHER

RESIDENCE

COLOR

AGE AT LAST

BIRTHDAY

 $\frac{d}{dx}$

BIRTHPLACE

OCCUPATION

**FULL
MAIDEN
NAME /**

MOTHER

RESIDENCE

COLOR

BIRTHPLACE**OCCUPATION**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was Shallborn at Victoria, B. C. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed.

Registrar.

Registrar.

NOV

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of *Beauregard*

City of *Montpelier*

No. *449 109 064 693* St.

Registration District No. *52*

State File No. *137133*

Hospital

Primary Registration District No. *2136*

Local Registrar's No.

FULL NAME OF CHILD *Baby Murphy*

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth.

2-9

(Month) (Day)

192*5*
(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth.

Number of child of this mother now living, including present birth.

FULL
NAME

FATHER

Geo. S. Murphy.

RESIDENCE

Montpelier

COLOR

white

AGE AT LAST
BIRTHDAY

26
(Years)

BIRTHPLACE

Welder O.S. & Ry

FULL
MAIDEN
NAME

MOTHER

Mable Gresham

RESIDENCE

Montpelier

COLOR

white

AGE AT LAST
BIRTHDAY

26
(Years)

BIRTHPLACE

Ida.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } *3 P* M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J.P. Gresham

(Physician or midwife)

Address

Montpelier 2nd St

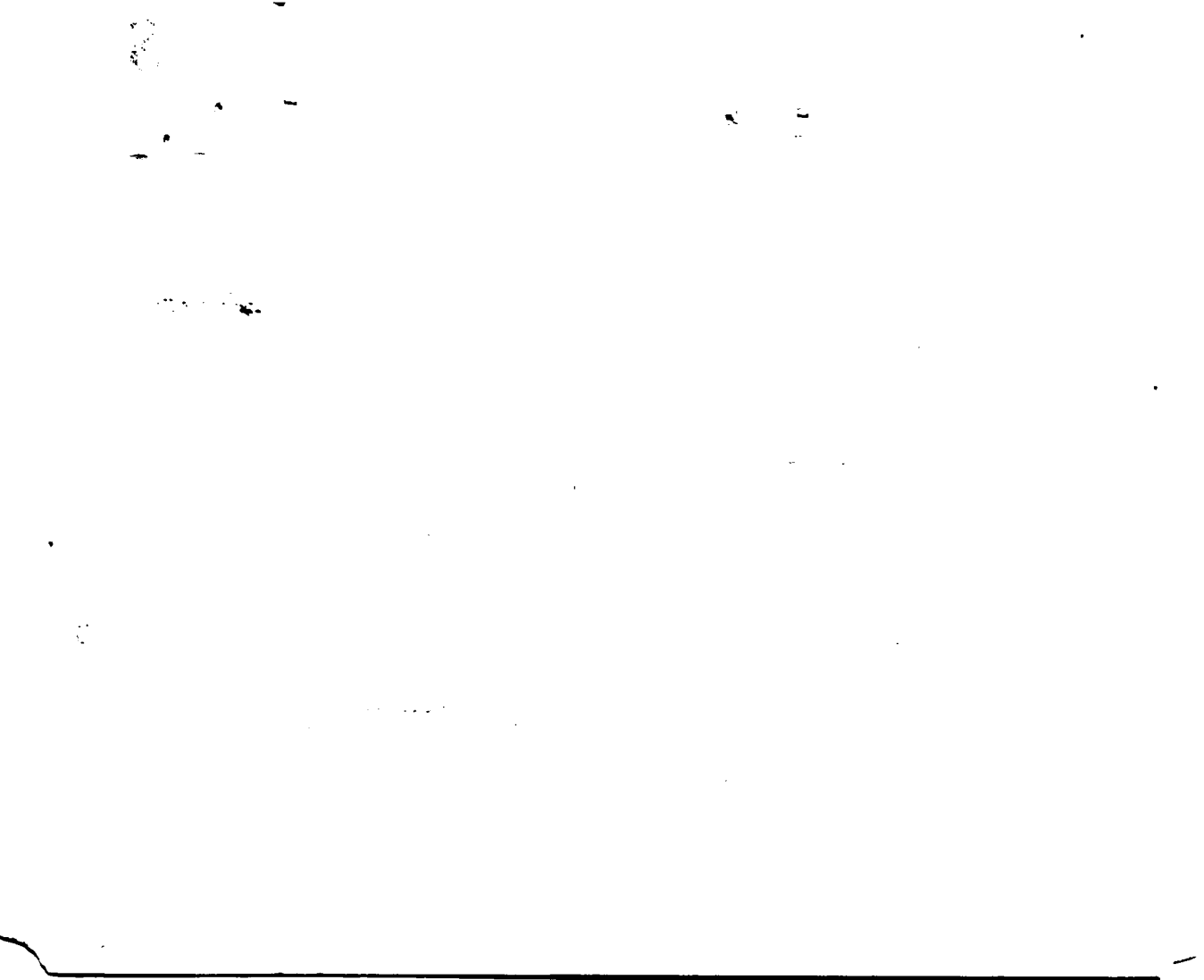
Filed

12/31

192*5*

Registrar.

Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **51649**

1. PLACE OF DEATH **RECEIVED**
County of **Blaine** Registration District No. **52**
City of **Montpelier** Primary Registration District No. **2136**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Murphy.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Infant**

6. DATE OF BIRTH

12 9 25
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Ida**

10. NAME OF FATHER **George S. Murphy**

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER **Mable Orchard**

13. BIRTHPLACE OF MOTHER

(State or Country) **Ida**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. P. Gaerhne**

(Address) **Montpelier**

15. **1731 25**

Filed **1731 25**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 9 25
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Premature Stillborn Infant**
that I last saw him alive on **12 9 25**

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Unknown (except above)

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. P. Gaerhne**

12 9 1925 (Address) **Montpelier**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Montpelier, Ida**

DATE OF BURIAL **17 10 1925**

20. UNDERTAKER **W. H. Williams**

ADDRESS **Montpelier, Ida**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

814 226 014 655

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

JAN 11

CERTIFICATE OF BIRTH

County of Canyon

BUREAU OF VITAL
STATISTICS

S 137285

City of Caldwell

Registration District No.

3

File No.

No. #3 St.

Primary Registration District No. 2005

Registered No. 238

Hospital

FULL NAME OF CHILD

Mary Elizabeth Hamilton

Sex of Child Female

Twin Triplet or other? } and } Number in order of birth
(To be answered only in event of plural births)

Legitimate? 108

Date of Birth 12/26 25 19 (Month) (Day) (Year)

FULL NAME FATHER Carl Barnes Hamilton

FULL MAIDEN NAME MOTHER Foreest O'Neal

RESIDENCE Homedale, Idaho

RESIDENCE Homedale, Idaho

COLOR White AGE AT LAST BIRTHDAY 35 (Years)

COLOR white AGE AT LAST BIRTHDAY 35 (Years)

BIRTHPLACE Missouri

BIRTHPLACE Missouri

OCCUPATION Farming

OCCUPATION Housewife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 9:15 P. M. on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) S. B. Dudley M. D.

(Physician or midwife)

Caldwell, Idaho

Given names added from a supplemental report.

Address

Filed 12-28-1925 John S. Meyer Registrar

Registrar

3. SIGNATURE OF CHIEF MEDICAL INSPECTOR
 4. SIGNATURE OF CHIEF CLERK
 5. SIGNATURE OF CHIEF NURSE
 6. SIGNATURE OF CHIEF LABORATORY
 7. SIGNATURE OF CHIEF X-RAY
 8. SIGNATURE OF CHIEF PATHOLOGY
 9. SIGNATURE OF CHIEF BACTERIOLOGY
 10. SIGNATURE OF CHIEF CHEMISTRY
 11. SIGNATURE OF CHIEF PHYSIOLOGY
 12. SIGNATURE OF CHIEF ANATOMY
 13. SIGNATURE OF CHIEF HISTOLOGY
 14. SIGNATURE OF CHIEF MICROBIOLOGY
 15. SIGNATURE OF CHIEF PHARMACOLOGY
 16. SIGNATURE OF CHIEF TOXICOLOGY
 17. SIGNATURE OF CHIEF RADIOLOGY
 18. SIGNATURE OF CHIEF ELECTROCARDIOGRAPHY
 19. SIGNATURE OF CHIEF ELECTROENCEPHALOGRAPHY
 20. SIGNATURE OF CHIEF ULTRASOUND
 21. SIGNATURE OF CHIEF COMPUTED TOMOGRAPHY
 22. SIGNATURE OF CHIEF MAGNETIC RESONANCE
 23. SIGNATURE OF CHIEF POSITRON EMISSION
 24. SIGNATURE OF CHIEF SINGLE-PHOTON EMISSION
 25. SIGNATURE OF CHIEF PETROGRAPHY
 26. SIGNATURE OF CHIEF FLUOROGRAPHY
 27. SIGNATURE OF CHIEF RADIOISOTOPE
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 98. SIGNATURE OF CHIEF RADIATION ANALYSIS
 99. SIGNATURE OF CHIEF RADIATION THERAPY
 100. SIGNATURE OF CHIEF RADIATION ONCOLOGY

1. NAME OF CHILD
 2. SEX
 3. DATE OF BIRTH
 4. TIME OF BIRTH
 5. PLACE OF BIRTH
 6. HOSPITAL
 7. PHYSICIAN
 8. NURSE
 9. LABORATORY
 10. X-RAY
 11. PATHOLOGY
 12. BACTERIOLOGY
 13. CHEMISTRY
 14. PHYSIOLOGY
 15. ANATOMY
 16. HISTOLOGY
 17. MICROBIOLOGY
 18. PHARMACOLOGY
 19. TOXICOLOGY
 20. RADIOLOGY
 21. ELECTROCARDIOGRAPHY
 22. ELECTROENCEPHALOGRAPHY
 23. ULTRASOUND
 24. COMPUTED TOMOGRAPHY
 25. MAGNETIC RESONANCE
 26. POSITRON EMISSION
 27. SINGLE-PHOTON EMISSION
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 96. RADIATION PHYSICS
 97. RADIATION PROTECTION
 98. RADIATION MONITORING
 99. RADIATION DETECTION
 100. RADIATION MEASUREMENT

1. PLACE OF DEATH

County of Cassia Registration District No. 3
 City of Caldwell Primary Registration District No. 2005
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Elizabeth Hamilton

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51742
 Local Registrar's No. 104

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single

6. DATE OF BIRTH

Dec 26 1925
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
 _____ hrs. or
 _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Carl B. Hamilton

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Forest Oreal

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl B. Hamilton

(Address) Caldwell #3

15.

Filed Dec. 27 - 1925 John D. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec - 26 - 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 - 1925 to Dec 26 1925, that I last saw him alive on Dec - 1925, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Strangulation - umbilical
Cord - before

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Short cord about neck

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. B. L. Welby M. D.

12-27-1925 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Placerville Ridge 12-27-1925

20. UNDERTAKER

ADDRESS

J. Beckham Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

THIS IS A COPY OF THE ORIGINAL RECORD OF THE BIRTH OF THE CHILD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

STATE OF OHIO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

County of _____ State of _____
Hospital _____
Name of Child _____

Sex _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Name of Mother _____
Name of Father _____
Name of Doctor _____
Name of Nurse _____
Name of Midwife _____

Signature of Doctor _____
Signature of Nurse _____
Signature of Midwife _____
Signature of Mother _____
Signature of Father _____

Residence _____
Color _____
Birthplace _____
Occupation _____
Manner of Death _____
Cause of Death _____
Place of Death _____
Date of Death _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of the child who was born on the date above stated on the day above stated.

When there was an attending physician or midwife, I certify that the child was born alive, full-term, and viable, and that neither parent nor child was under the influence of any drug or alcohol at the time of birth.

Signature of Physician or Midwife _____
Date _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V, S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

51866

1. PLACE OF DEATH

County of *Ada*Registration District No. *93*City of *Idaho*Primary Registration District No. *2371*

State File No.

Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male**White*

(Write the word)

6. DATE OF BIRTH

*March**30**1925*

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father

*Matt Stritzel*11. BIRTHPLACE
OF FATHER

(State or Country)

*Austria*12. MAIDEN NAME
OF MOTHER*Margaret Rozman*13. BIRTHPLACE
OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Matt Stritzel

(Address)

15.

*March 21*Filed *Apr 1*19 *25**Dan Lyle*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*March 20*19 *25*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 20* 19 *25* to *March 20* 19 *25*that I last saw him alive on *March 20* 19 *25*,
and that death occurred on the date stated above, at *3:45* P. M.

The CAUSE OF DEATH* was as follows:

*Delay in delivery
Shoulder presentation necessitating Version.*

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Saylor

M. D.

(Address)

Orapolis, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Peck Cemetery

DATE OF BURIAL

3/21 19 *25*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first.. the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

593-113 09433
County of ButteCity of Challis

No. St.

Hospital

FULL NAME OF CHILD not named

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

RECEIVED

JAN 7 1926

CERTIFICATE OF BIRTH

BUREAU OF VITAL
STATISTICSNo. 108 State File No. 137387Primary Registration District No. 2186 Local Registrar's No. 53

(Certificate of no value without full name of child)

Sex of
Child

M

Twin
Triplet
or other?

}

and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birthSept 13 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1Number of child of this mother now living, including present birth 1FULL
NAME

FATHER

Edgarline Hickinson

RESIDENCE

Challis

COLOR

Wh

AGE AT LAST

BIRTHDAY

27
(Years)

BIRTHPLACE

Idaho

OCCUPATION

MerchantFULL
MAIDEN
NAME

MOTHER

Jessie N. C. Cipe

RESIDENCE

Challis

COLOR

Wh

AGE AT LAST

BIRTHDAY

27
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Challis Idaho M.
on the date above stated.*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

E. C. Hurdley M.D.

(Physician or midwife)

Address

Filed

Jan 5 1926 Hazel Jones
Registrar.

Registrar.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BlaineCity of Challis

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

JAN 7 1925

Registration District No. 108

BUREAU OF VITAL STATISTICS

Registration District No. 2486

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 51761Local Registrar's No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Wh5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

Sept 131925

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FatherFranklin Nickerson11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERJessie McClure13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Jan 5 19251925Hazel Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 131925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19.....

to

19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Swan moribund by boarded
Large ventral pneumonia
gullet

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

E. S. Hurley

M. D.

19.....

(Address)

Challis, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....days. State.....yrs.....mos.....ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ChallisSept 13 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
419 222 099 995		DEPARTMENT OF PUBLIC WELFARE	
County of <u>Blaine</u>		BUREAU OF VITAL STATISTICS	
City of <u>Chaplain</u>		RECEIVED JAN 7 1925	
No. _____		BUREAU OF VITAL STATISTICS	
St. _____		Reg. District No. <u>108</u>	
Hospital _____		State File No. _____	
Primary Registration District No. <u>2/86</u>		Local Registrar's No. <u>64</u>	
FULL NAME OF CHILD <u>Mary Maraffio</u>		CERTIFICATE OF BIRTH S 137404	
(Certificate of no value without full name of child)			
Sex of Child <u>Fe</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>
Date of birth <u>Dec 22</u> 192 <u>5</u>		(Month) (Day) (Year)	
What bactericidal solution was used in eyes? _____			
Number of child of this mother, including present birth <u>3</u>		Number of child of this mother now living, including present birth <u>2</u>	
FATHER		MOTHER	
FULL NAME <u>Andrew Maraffio</u>		FULL MAIDEN NAME <u>Mary Gini</u>	
RESIDENCE <u>Chaplain</u>		RESIDENCE <u>Chaplain</u>	
COLOR <u>Wh.</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)	COLOR <u>Wh.</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Italy</u>		BIRTHPLACE <u>Italy</u>	
OCCUPATION <u>Ranchman</u>		OCCUPATION <u>Housewife</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
I hereby certify that I attended the birth of this child, who was { Born alive } on the date above stated. { Stillborn } at <u>1 A. M.</u>			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.		(Signature) <u>Mrs. Caterina Maraffio</u>	
Give names added from a supplemental report.		(Physician or midwife)	
_____, 192 <u>5</u>		Address _____	
_____, 192 <u>5</u>		Filed <u>Jan 5</u> 192 <u>5</u> <u>Myzel Jones</u>	
Registrar.		Registrar.	

MEMORANDUM FOR THE RECORD

TO : THE SECRETARY OF THE ARMY

FROM : THE SECRETARY OF THE ARMY

1. The purpose of this memorandum is to provide a summary of the information received from the various sources regarding the activities of the [redacted] during the period [redacted] to [redacted].

2. The information received from the various sources indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

3. The information received from the various sources also indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

4. The information received from the various sources also indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

5. The information received from the various sources also indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

6. The information received from the various sources also indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

7. The information received from the various sources also indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

8. The information received from the various sources also indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

9. The information received from the various sources also indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

10. The information received from the various sources also indicates that the [redacted] has been engaged in a series of activities which are of a [redacted] nature. These activities include [redacted] and [redacted].

State of Idaho

DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, JAN 12 1926

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

RECEIVED
MAR 19
BUREAU OF VITAL
STATISTICS

of
Birth

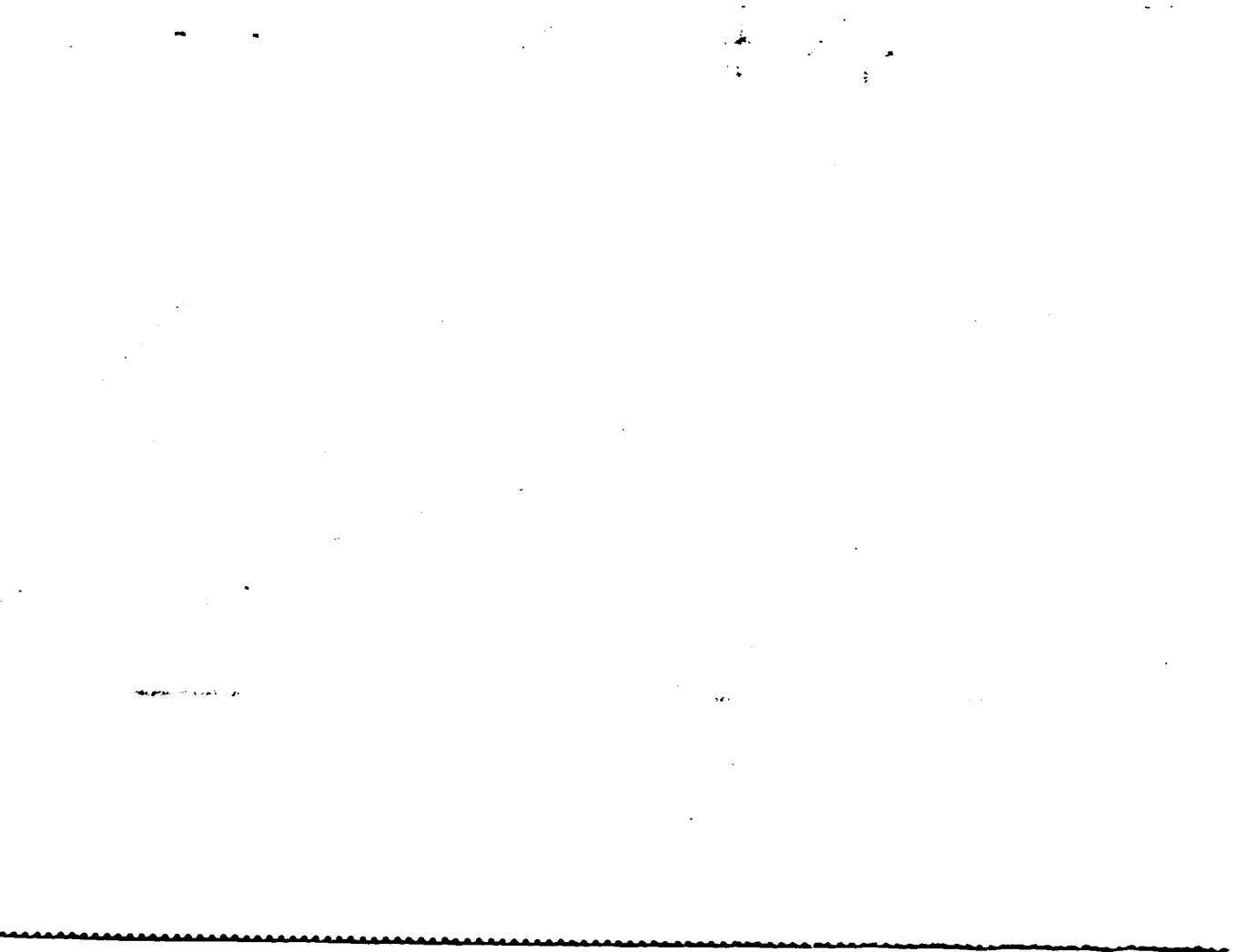
CITY Clayton, FILE NO. 157404
ST. DATE OF BIRTH December 22d, 1925.
COUNTY Custer, SEX OF CHILD Girl.
FATHER Andrew Maraffio MOTHER Mary Gini.
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Mary Maraffio.

Andrew Maraffio

Signature of Father or Mother.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Custer
City of Lexington

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

JAN 7 1926

BUREAU OF VITAL STATISTICS

(No.

Betty Maraffio

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51763

Local Registrar's No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Fe

Wh

(Write the word)

6. DATE OF BIRTH

Dec

22

1925

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF Father

Andrew Maraffio

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Mary Gini

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov 5

1926

Razel Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

22

1925

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Razel Jones

M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lexington

Dec 22 1925

20. UNDERTAKER

ADDRESS

Relative

Lexington

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of FranklinCity of FairviewNo. 916 101021 269

St.

Registration District No. 27State File No. 27

Hospital

Primary Registration District No. 2119Local Registrar's No. 262

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of
ChildMaleTwin
Triplet
or other?} and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate? yesDate of
birthDec. 1, 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes? 20 % AgNumber of child of this mother, including present birth 6Number of child of this mother now living, including present birth 4FULL
NAME

FATHER

Henry H. RawlingsFULL
MAIDEN
NAME

MOTHER

Tresse Sornson

RESIDENCE

Fairview, Idaho

RESIDENCE

Fairview, Idaho

COLOR

White

AGE AT LAST

32

BIRTHDAY

(Years)

COLOR

White

AGE AT LAST

30

BIRTHDAY

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

New Jersey

OCCUPATION

Farming

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 9:30 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Physician

(Physician or midwife)

Preston, Idaho

Address

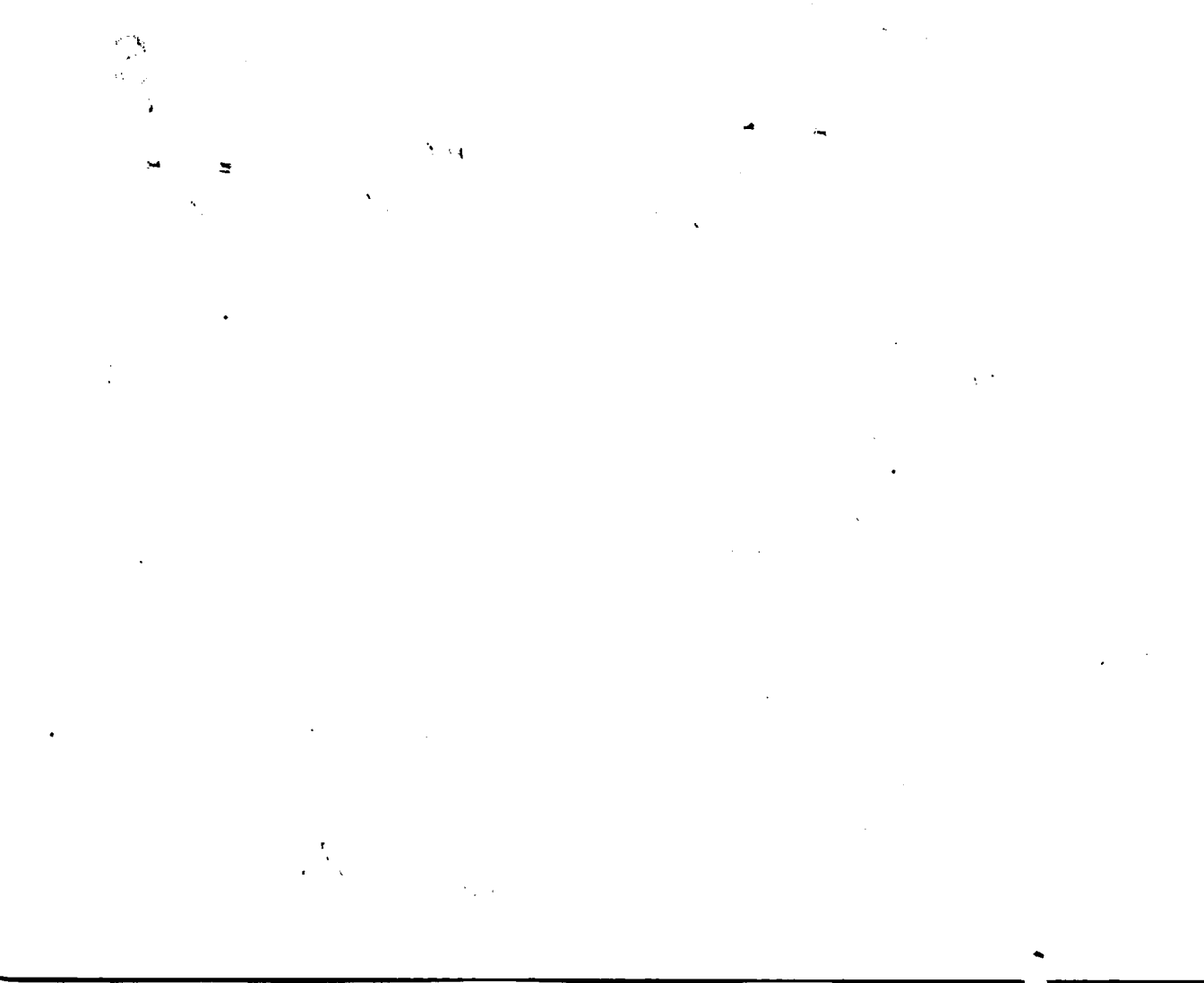
Filed

Jan. 5, 1926

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin

City of Fairview

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

St. Rawlings

2. FULL NAME

Still born (Rawlings.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51776

Local Registrar's No. 67

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

Dec. 1, 1925

(Month)

(Day)

(Year)

7. AGE

0

Yrs.

0

Mos.

0

ds.

IF LESS than 1 day how many hrs. or min.?

0

min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fairview, Idaho

10. NAME OF

Father

Henry H. Rawlings.

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Tresse Sernson

13. BIRTHPLACE

OF MOTHER

(State or Country)

New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry H. Rawlings

(Address)

Preston, Idaho. R.F.D. #5

15.

Filed

Jan. 5

1926

C. R. Carter

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-1-1925 to 12-1-1925

that I last saw him alive on 12-1-1925 and that death occurred on the date stated above, at 1306 M.

The CAUSE OF DEATH* was as follows:

Accidental premature separation of placenta

(Duration) yrs. 12 mos. 12 ds.

Contributory (Secondary)

(Duration) yrs. 12 mos. 12 ds.

(Signed)

C. R. Carter

M. D.

12-1-1925

(Address)

Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. In the State. yrs. mos. ds. Life mos. 12 days. 12 State. yrs. mos. ds. Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Fairview, Idaho

DATE OF BURIAL

12.2 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicæmia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County Teton
City of Teton, Idaho
No. 719-217022 255 St. Registration District No. 99 State File No. 137456
Hospital..... Primary Registration District No. 2177 Local Registrar's No. 367
FULL NAME OF CHILD Baby Gardner
(Certificate of no value without full name of child.)

Sex of Child <u>Girl</u>	Twin Triplet or other? <u>and</u> Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Sept 17</u> 192 <u>5</u> (Month) (Day) (Year)
--------------------------	--	------------------------	---

What bactericidal solution was used in eyes? 1st Silver nitrate

Number of child of this mother, including present birth 1st Number of child of this mother now living, including present birth

FULL NAME <u>Stephen J. Gardner</u>	FULL MAIDEN NAME <u>Verma Beasley</u>
RESIDENCE <u>Teton, Idaho</u>	RESIDENCE <u>Teton, Idaho</u>
COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>17</u> (Years)
BIRTHPLACE <u>Teton, Idaho</u>	BIRTHPLACE <u>Utah</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive on the date above stated. Stillborn

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Frank Watkins
(Physician or midwife)

Give names added from a supplemental report.

Address.....

Filed 12/28 1925 Wm. H. Hansen

Registrar.

Registrar.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF IOWA

2

TO THE NAME OF CHILD
(Print name of child without full name of child)

100-443887-100

NAME FULL NAME FULL NAME FULL

AGE AT LAST BIRTHDAY 9 09TH DAY 1944

[Faint mirrored text from reverse side]

I hereby certify that I attended the birth of this child, who was born on the date above stated.

Give names aged from a confidential report.

100

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

415-000-022-415
PLACE OF BIRTH

County of Tremont
City of Chester

No. _____ St. _____ Registrar's District No. 99 State File No. _____

Hospital _____ Primary Registration District No. 177 Local Registrar's No. 378

FULL NAME OF CHILD Baby Davis

(Certificate of no value without full name of child)

Sex of Child	Twin Triplet or other?	and { Number in order of birth	Legiti- mate?	Date of birth	<u>Dec 25</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)	<u>192</u>

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER
FULL NAME Walter B Davis
RESIDENCE Chester
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Harper Co. Kans.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Bessie Davis
RESIDENCE _____
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Chester
OCCUPATION House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at still M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Mrs Henry B. Brown
midwife
(Physician or midwife)

Address Chester, Idaho

Filed 12/28 1925 Wm. Hansen

Registrar.

Registrar.

2. If it is found that the child is illegitimate, the father's name shall be given in the report, and the mother's name shall be given in the report, and the child shall be registered as illegitimate.

Registrar.
 Date.
 Address.
 (Signature of Registrar)

I hereby certify that I attended the birth of the child, who was born on the date above stated.
 *When there was no attending physician or midwife then the father, householder or mother, should make the return, and should sign the return, and the child is one that neither priest nor shows other evidence of the after birth.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 OCCUPATION
 BIRTHPLACE
 COLOR
 AGE AT LAST BIRTHDAY (Years)
 RESIDENCE
 FATHER
 FULL NAME
 Number of child of this mother, including deceased children
 MOTHER
 FULL NAME
 Maiden Name
 RESIDENCE
 Number of child of this mother, including deceased children

What bacteriological solution was used in case of

Sex of Child
 Twin
 Triplet
 or other
 Number of birth
 (If a boy, record number of place in family)

FULL NAME OF CHILD
 Hospital
 Date of Birth
 District No.
 Registrar's No.

Registrar.
 Date.
 Address.
 (Signature of Registrar)

I hereby certify that I attended the birth of the child, who was born on the date above stated.
 *When there was no attending physician or midwife then the father, householder or mother, should make the return, and should sign the return, and the child is one that neither priest nor shows other evidence of the after birth.

CERTIFICATE OF BIRTH
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 STATE OF ILLINOIS
 COUNTY OF
 City of
 District No.
 Registrar's No.
 Date of Birth
 District No.
 Registrar's No.
 Sex of Child
 Twin
 Triplet
 or other
 Number of birth
 (If a boy, record number of place in family)

What bacteriological solution was used in case of

HAIRIN KEERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH **RECEIVED** **CERTIFICATE OF DEATH**
 County of Fremont JAN 6 Registration District No. 99
 City of Chester **BUREAU** Primary Registration District No. 2177
 If death occurs away from usual residence, give facts called for under special information. STA. (No. St.)
 2. FULL NAME Willie Brown

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 State File No. 51774
 Local Registrar's No. 130

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word)

6. DATE OF BIRTH Dec. 7 1925
 (Month) (Day) (Year)

7. AGE non hrs. or min.?
 Yrs. Mos. ds.

8. OCCUPATION
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Chester

10. NAME OF FATHER Walter B. Davis

11. BIRTHPLACE OF FATHER (State or Country) Harper Co. Conn

12. MAIDEN NAME OF MOTHER Irene Davis

13. BIRTHPLACE OF MOTHER (State or Country) Chester Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Walter B Davis
 (Address) Chester Idaho

15. Filled Dec. 7 1925 Wm W. Hansen
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 7 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1925 to Dec 7 1925
 that I last saw him alive on Born Dec 7 1925
 and that death occurred on the date stated above, at 10:10 PM.
 The CAUSE OF DEATH* was as follows:
Willie Brown

(Duration) yrs. mos. ds.
 Contributory (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) Mrs H. G. Brown M. D.
 12/7 1925 (Address) Chester Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
 At place of death yrs. mos. days. State yrs. mos. ds.
 Where was disease contracted if not at place of death?
 Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Chester DATE OF BURIAL 12/8 1925

20. UNDERTAKER None ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman, "Manager, "Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers, who receive a definite salary,** may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**") **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia,**" unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, "Anaemia**" (merely symptomatic), "**Atrophy, "Collapse, "Coma, "Convulsions, "Debility, "Congenital, "Senile, etc.). "Dropsy, "Exhaustion, "Heart Failure, "Hemorrhage, "Inanition, "Marasmus, "Old age, "Shock, "Uraemia, "Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

863-113 027 819
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 137520

County of Jerome

City of Edin

No. _____ St. _____

Registration District No. 23

File No. _____

Hospital _____

Primary Registration District No. 2017

Registered No. 41

FULL NAME OF CHILD D. M. Old Holmes

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 19, 1925</u> (Month) (Day) (Year)
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What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 2 ... Number of child of this mother now living, including present birth... 1 ...

FULL NAME Rudolph C. Holmes
RESIDENCE Edin, Idaho. R.F.D. No. 1
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Shelby, Ohio
OCCUPATION Farmer

FULL MAIDEN NAME Ruby B. Harris
RESIDENCE Edin, Idaho. R.F.D. No. 1
COLOR White AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Penmar, Miss. Miss.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 7:00 P. M. on the date above stated. (born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. P. Passer, M.D.
Turn Falls, Id.
(Physician or midwife)

Give names added from a supplemental report.

_____, 19____

Address _____

Filed 192 E. L. Berry

Registrar.

Registrar.

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

DEC 22 1925

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH Eden BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 51798

County of Jerome State of Idaho Registration District No. 1

City of Eden Primary Registration District No. Eden R.T.D. 1

Local Registrar's No. 157-a

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Donald H. Holmes (Holmes)

(a) Residence. No. St.

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 13 1925

7 AGE Years Months Days If LESS than 1 day, 12 hrs. or mos.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (Farmer)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eden Ida (State or country)

10 NAME OF FATHER R. O. Holmes

11 BIRTHPLACE OF FATHER (city or town) Wisc. (State or country)

12 MAIDEN NAME OF MOTHER Ruby Harris

13 BIRTHPLACE OF MOTHER (city or town) Idaho (State or country)

14 Informant H. O. Holmes (Address) Eden R.T.D. 1 Ida

15 Filed Dec 21 1925 E. L. Barry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 13 1925 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1925, to Dec 12, 1925, that I last saw him alive on , 19 , and that death occurred, on the date stated above, at m.

18 THE CAUSE OF DEATH was as follows: Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Paeen, M. D. Dec 15, 1925 (Address) Turn Falls Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Turn Falls Date of Burial Dec 18 1925

20. Undertaker J. J. Hoosman Address Turn Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

316-217028-212.
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Kootenai

JAN 7

City of Conrad

BUREAU OF
STATISTICS

CERTIFICATE OF BIRTH

S 137541

No. ✓ St. Registration District No. 30 State File No. 1051

Hospital Le Da Primary Registration District No. 1051 Local Registrar's No. 1461

FULL NAME OF CHILD Barbara Ann Saffery

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? one and { Number in order of birth one } Legitimate? yes Date of birth Dec 17 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth one Number of child of this mother now living, including present birth one

FATHER
FULL NAME Robert B Saffery
RESIDENCE Conrad
COLOR white AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Idaho
OCCUPATION Engineer

MOTHER
FULL MAIDEN NAME Maud A Baker
RESIDENCE Conrad
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 4 A M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) J. H. Holder
Physician
(Physician or midwife)

Address Conrad Idaho

Filed Jan 4 1926 D. E. Brennan
Registrar. Registrar.

THIS IS A CERTIFICATE OF BIRTH FOR THE CHILD OF THE MOTHER AND FATHER NAMED ABOVE. IT IS TO BE USED TO PROVE THE CHILD'S AGE AND TO SHOW THAT THE CHILD WAS BORN IN THE STATE OF IDAHO. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF BIRTHS AND DEATHS, AND IT IS TO BE PRODUCED TO THE COURT IN CASE OF A DISPUTE AS TO THE CHILD'S AGE.

(The names added from a supplemental report show other evidence of the child's birth. It should make this return a reliable one, inasmuch as the father has shown that there was no attending physician or midwife from the father's standpoint.)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Male } { Female } at { Boise } { Idaho } on the date above stated.

(Signature of physician or midwife)
 Address _____
 City _____ State _____

FATHER		MOTHER	
NAME	RESIDENCE	NAME	RESIDENCE
FULL NAME		FULL NAME	
COLOR		COLOR	
BIRTHPLACE		BIRTHPLACE	
AGE AT LAST BIRTHDAY (Years)		AGE AT LAST BIRTHDAY (Years)	
OCCUPATION		OCCUPATION	

CHILD		MOTHER	
NAME	RESIDENCE	NAME	RESIDENCE
FULL NAME		FULL NAME	
COLOR		COLOR	
BIRTHPLACE		BIRTHPLACE	
AGE AT LAST BIRTHDAY (Years)		AGE AT LAST BIRTHDAY (Years)	
OCCUPATION		OCCUPATION	

What part of the solution was used in cases?

Number of child of this mother, including present birth _____

Number of child of no wife without full name of child _____

Full name of child _____

State _____

City _____

County _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

31810

1. PLACE OF DEATH

County of Boone Registration District No. 30

City of Boone Primary Registration District No. 1757

If death occurs away from usual residence, give facts called for under special information. (No. Boone & Boone)

State File No. 1413

Local Registrar's No. 1413

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barbra Lofferty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word)

6. DATE OF BIRTH

Dec 17 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF Father

R. B. Lofferty

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Maudie A. Baker

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. B. Lofferty

(Address) Boone & Boone

15.

Filed Jan 4 1925 Boone

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 17 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Stillborn Due to hemorrhage of brain

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. H. Holden M. D.

12/17/1925 (Address) Boone & Boone

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery 12/17 1925

20. UNDERTAKER

ADDRESS

R. B. Mooney Boone & Boone

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

755-202028-219
PLACE OF BIRTH

RECEIVED

DEC 16 1925

STATE OF IDAHO

S

County of Kootenai

BUREAU OF VITAL STATISTICS

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of Spirit Lake

STATISTICS

CERTIFICATE OF BIRTH 137548

No. St. Registration District No. State File No.

Hospital Lewis & Clark Primary Registration District No. 45 Local Registrar's No. 35

FULL NAME OF CHILD Filora Pennanen

(Certificate of no value without full name of child)

Sex of Child <u>♀</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>Nov 2</u> 192 <u>5</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Alex Pennanen
RESIDENCE Spirit Lake
COLOR W AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Finland
OCCUPATION Lumberman

MOTHER
FULL MAIDEN NAME Hilgo Sari
RESIDENCE Spirit Lake
COLOR W AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Finland
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 10 30 9 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Nov 10 1925
acspomer
Registrar.

(Signature) Roscoe L. Clark

(Physician or midwife)

Address Spirit Lake, Ida

Filed 192

Registrar.

THIS IS TO CERTIFY THAT THE CHILD NAMED HEREIN WAS BORN AT THE PLACE AND DATE HEREIN SET FORTH AND THAT THE SIGNATURE OF THE FATHER AND MOTHER ARE HEREIN SET FORTH AND THAT THE SIGNATURE OF THE FATHER AND MOTHER ARE HEREIN SET FORTH

Give names added from a supplemental report.
 Show first signature of the father.
 Child is one that neither of either sex
 should make the report a child born
 or female from the father born before
 When there was no attending physician
 at the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Addressed _____
 Registered _____
 I hereby certify that I attended the birth of this child, who was _____
 (Physician or midwife)
 (Signature)

OCCUPATION _____
 BIRTHPLACE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 OCCUPATION _____
 BIRTHPLACE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 NAME _____
 FATHER _____
 MOTHER _____

Number of child of this mother, including medical _____
 What antiseptical solution was used in _____
 (To be answered only in event of placental) _____
 Child of _____
 Sex of _____
 (To be answered only in event of placental) _____
 Location _____
 Location _____
 Location _____

BUILD NAME OF CHILD _____
 Hospital _____
 No. _____
 City of _____
 County of _____

DEPARTMENT OF HEALTH STAMPEO
 HOSPITAL OF GREAT STAMPEO
 187548
 2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
JEC
CERTIFICATE OF DEATH
Registration District No. 45
Registration District No.

DO NOT WRITE IN THIS SPACE

State File No. 51799

Local Registrar's No. 17

PLACE OF DEATH

County of Kootenai
City of Spirit Lake

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Flora Pennman

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov 2 - 1925

7 AGE Years Months Days 1 If LESS than day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho

10 NAME OF FATHER Alex Pennman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland

12 MAIDEN NAME OF MOTHER Lily Sari

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Finland

14 Informant. Alex Pennman (Address)

15 Filed Nov 3, 1925 A. C. Spooner Registrar

MEDICAL CERTIFICATE OF DEATH 1896

16 DATE OF DEATH (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born (Baby died at least 24-48 hours before birth) (Knot in cord which was very short, delivery (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ross T. Clark, M. D. Nov. 3, 1925 (Address) Spirit Lake, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial Spirit Lake 11-3 1925

20. Undertaker Address R. C. Carstedt Rathdrum

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

215 723 028-363.

County of Rootenau

City of Spirit Lake

No.

St.

Registration District No.

45-

State File No.

137551

S

Hospital Lewis & Clark

Primary Registration District No.

Local Registrar's No. 38

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Male

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Nov 28

1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Thomas William Barnes Jr

RESIDENCE

Spirit Lake

COLOR

White

AGE AT LAST
BIRTHDAY

24

(Years)

BIRTHPLACE

London England

OCCUPATION

Machinist

FULL
MAIDEN
NAME

MOTHER

Dorothy Ina Lockman

RESIDENCE

Spirit Lake

COLOR

White

AGE AT LAST
BIRTHDAY

18

(Years)

BIRTHPLACE

Colorado Springs Colorado

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3 P M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

R. Gerlach M.D.
Phys.

(Physician or midwife)

Address

Spirit Lake

Filed

Nov 30 1925

Acspooner

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

268 119 029 625
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

137563

County of Latah JAN 9
City of amoscow
No. _____ St. _____ Registration District No. 61 File No. S
Hospital Inland Primary Registration District No. 1011 Registered No. 162
FULL NAME OF CHILD Lawrence Boyd
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ { and } Number in order of birth <u>6</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec 19</u> 192 <u>5</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... 6 ... Number of child of this mother now living, including present birth... 5 ...

FATHER
FULL NAME Herman Boyd
RESIDENCE Troy
COLOR white
BIRTHPLACE Norway
OCCUPATION farmer
AGE AT LAST BIRTHDAY 34 1/2 (Years)

MOTHER
FULL MAIDEN NAME Zina Osvog
RESIDENCE Troy
COLOR white
BIRTHPLACE Norway
OCCUPATION Hwf
AGE AT LAST BIRTHDAY 32 (Years)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed 12-20 1925

Registrar.

Registrar.

3



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of LatahCity of Moscow

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

JAN 9 1925

BUREAU OF VITAL STATISTICS

STATION

Registration District No. 61Registration District No. 1011

St.)

2. FULL NAME

Lawrence BoydFile No. 51838Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant

(Write the word.)

6. DATE OF BIRTH

Dec. 19

(Month)

(Day)

1925

(Year)

7. AGE

Yrs. StillbornMos. Stillborn

IF LESS than 1 day

how many hrs.or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant - (Stillborn)

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Inland Hospital - Moscow

10. NAME OF FATHER

Herman Boyd

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Sina Bsvog

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Herman Boyd
Tray, Idaho

15.

Filed

12-291925M. A. Carithers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 19

(Month)

(Day)

1925

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 19 - 1925 to Dec. 19 - 1925that I last saw him alive on Dec. 19 - 1925and that death occurred on the date stated above, at 7:57 P.M.

The CAUSE OF DEATH* was as follows:

Unknown(Duration) — Yrs. — mos. — ds.Contributory
(Secondary)(Duration) — Yrs. — mos. — ds.

(Signed)

H. W. W. H. M. D.(Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tray, Ida.12-21 1925

20. UNDERTAKER

ADDRESS

John RichardTray, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N: B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

432-131022-134
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Fremont

RECEIVED

CERTIFICATE OF BIRTH

City of Teton

JAN 9

No.

St.

Registration District No.

State File No.

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate?

Date of
birth

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

1926

Registrar.

Registrar.



110D

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Minidoka

City of Hayden

No. 452-207034 753 St.

Hospital

Registration District No. 19 State File No. 137648

Primary Registration District No. 2015 Local Registrar's No. 179

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin <u>yes</u> or other? <u>yes</u> and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec 7</u> 192 <u>5</u> (Month) (Day) (Year)
----------------------------	--	------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER	MOTHER
FULL NAME <u>Henry E. De Bond</u>	FULL MAIDEN NAME <u>Virginia Peters</u>
RESIDENCE <u>Hayden</u>	RESIDENCE <u>Hayden</u>
COLOR <u>white</u>	COLOR <u>white</u>
AGE AT LAST BIRTHDAY <u>33</u> (Years)	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Ida.</u>	BIRTHPLACE <u>Ida.</u>
OCCUPATION <u>laborer</u>	OCCUPATION <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive or Stillborn at 9:10 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) E. E. Ehm

(Physician or midwife)

Address 1 Rusty Ida

Filed 12-12-25 E. E. Ehm

Registrar.

Registrar.

[REDACTED]

100

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Minidoka

City of Heyburn

No. 452-201034753

RECEIVED

JAN 7

BUREAU OF VITAL

CERTIFICATE OF BIRTH

137649

Hospital

Registration District No. 19

State File No.

Registration District No. 2013

Local Registrar's No. 180

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other

yes

and

Number
in order
of birth

2

Legiti-
mate?

yes

Date of
birth

Dec 7

1925

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

Henry E. De Bord

RESIDENCE

Heyburn

COLOR

white

AGE AT LAST

BIRTHDAY 33

(Years)

BIRTHPLACE

Ida.

OCCUPATION

laborer

FULL
MAIDEN
NAME

MOTHER

Virginia Peters

RESIDENCE

Heyburn

COLOR

white

AGE AT LAST

BIRTHDAY 28

(Years)

BIRTHPLACE

Ida.

OCCUPATION

Hom.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was { born alive } at 9 20 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

E. E. Elmore

M.D.

(Physician or midwife)

Address

Trufert

Filed

12-12 1925

E. E. Elmore

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Banerof

No. 962-129003-493 St. Bannock

Hospital St. Bannock

FEB 6

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 137955

State File No. 84

Primary Registration District No. 2161 Local Registrar's No. 186

FULL NAME OF CHILD

No name.

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

— } and {

Number
in order
of birth

—

Legiti-
mate?

yes

Date of
birth

Dec. 29, 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Robt. G. Robinson

RESIDENCE

Banerof

COLOR

White

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

Maryland

OCCUPATION

Mgr. Telephone Office

FULL
MAIDEN
NAME

MOTHER

Edith L. Miller

RESIDENCE

Banerof

COLOR

White

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 1:25 P. M.
on the date above stated. (Premature - Purpura Eclampsia)

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

(Signature)

Russell Sigert

(Physician or midwife)

Give names added from a supplemental report.

, 192

Registrar.

Address

Soda Springs

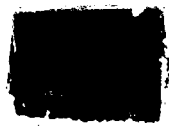
Filed

1-6-1926

Mrs. G. J. Fitz

Registrar.

3



1975-10-10

Dup. of 1925-152604

1. PLACE OF DEATH

County of BannockCity of Bancroft

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

no name RobinsonRECEIVED
CERTIFICATE OF DEATHRegistration District No. 84
Primary Registration District No. 2161

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 51958Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robert Alexander Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Edith Leona Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb-1- 1926Mrs. L. G. Fitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec-29- 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 29 1925, to Dec 26 1925that I last saw h. alive on Stillborn 1925and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:

still-birth
Pre-mature - 7 months

(Duration) Yrs. mos. ds.

Contributory (Secondary) Eclampsia

(Duration) yrs. mos. ds.

(Signed) Russell Tignor M. D.15 1926 (Address) Idaho Springs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Blackfoot

DATE OF BURIAL

12/28 1926

20. UNDERTAKER

Had none

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

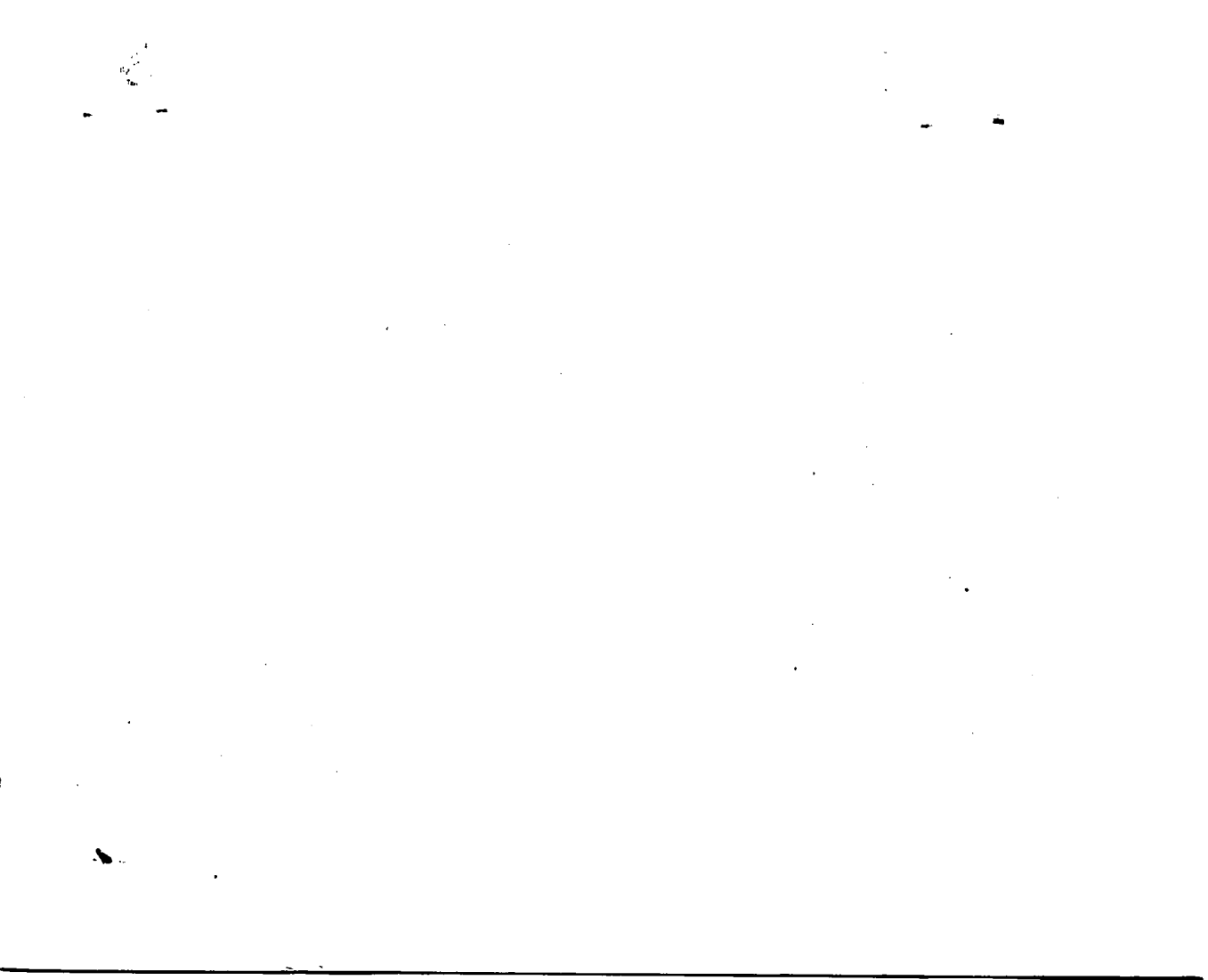
PLACE OF BIRTH		STATE OF IDAHO	
394 116 003 791 Bannock, County of		DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS	
City of		CERTIFICATE OF BIRTH	
No. 745 N. 7th.		State File No. 137993	
Hospital <i>St. Anthony's</i>		Primary Registration District No. 3161 Local Registrar's No. 7370	
FULL NAME OF CHILD		Still born.	
(Certificate of no value without full name of child)			
Sex of Child	Male.	Twin Triplet or other?	
		and	
		Number in order of birth	
		(To be answered only in event of plural births)	
Legitimate?	Yes.	Date of birth	Dec. 16. 1925
		(Month)	(Day) (Year)
What bactericidal solution was used in eyes? 10 of Neo silvol.			
Number of child of this mother, including present birth 6		Number of child of this mother now living, including present birth 0	
FULL NAME FATHER		FULL NAME MOTHER	
August Cimaroli.		Madeline Granchette.	
RESIDENCE		RESIDENCE	
745 North 7th. Ave.		745 North 7th. Ave.	
COLOR	White.	COLOR	White.
AGE AT LAST BIRTHDAY	49 (Years)	AGE AT LAST BIRTHDAY	30 (Years)
BIRTHPLACE		BIRTHPLACE	
Rome, Italy.		Naples, Italy.	
OCCUPATION		OCCUPATION	
Machinist.		Housewife.	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.			
I hereby certify that I attended the birth of this child, who was { Still born } 6/30 A. M. on the date above stated.			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.			
Give names added from a supplemental report.			
, 192			
Registrar.		Registrar.	

(Signature)

William F. Howard MD
(Physician or midwife)

Address Pocat 110, Idaho

Filed 1-1 1926
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

STATE OF IDAHO
JAN 19 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 51967

PLACE OF DEATH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

County of Barnett Registration District No. 78
City of Coartee Primary Registration District No. 7461 Local Registrar's No. 426
(No. St. Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Cimaroli

(a) Residence. No. 745 No 7th St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Italian 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Still Born If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) Coartee Idaho

10 NAME OF FATHER Agustino Cimaroli

11 BIRTHPLACE OF FATHER (city or town, State or country) Italy

12 MAIDEN NAME OF MOTHER Margherita Panchetta

13 BIRTHPLACE OF MOTHER (city or town, State or country) Italy

14 Informant Agustino Cimaroli
(Address) Coartee Idaho

15 Filed 12/12, 19 25

Registrar W. Young

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 16 19 25
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That Stillborn died from Stillborn to Dec 16, 1925, that I last saw h. alive on Stillborn Dec 16, 1925, and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows:

Still born
Version retained head
(duration) yrs. mos. ds.
CONTRIBUTORY Deformed pelvis mother
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Version

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Dr. H. L. Lowney M. D. (Address) Coartee Idaho
12/16, 19 25

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Date of Burial Dec 16 1925

20 Undertaker Chumacku Address Coartee Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

296 14 003-365

PLACE OF BIRTH

RECEIVED
JAN 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cornock

City of Cocatulle

No. 544 St. So. Arth.

Hospital none

BUREAU OF VITAL
STATISTICS

Registration District No. 28

Primary Registration District No. 2161

CERTIFICATE OF BIRTH

State File No. 137997

Local Registrar's No. 2874

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child m

Twin
Triplet
or other?
(To be answered only in event of plural births)

Number
in order
of birth

Legiti-
mate? Yes

Date of
birth 12/14/25

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Joshua L. Brian

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth 2

FATHER
FULL
NAME

William J. Brian

RESIDENCE

544 So. Arth. Cocatulle, Ida.

COLOR

White

AGE AT LAST
BIRTHDAY 40

(Years)

BIRTHPLACE

Salt Lake City

OCCUPATION

car. mfg. O.S.R.

MOTHER
FULL
MAIDEN
NAME

Pearl Long

RESIDENCE

544 So. Arth. Cocatulle

COLOR

White

AGE AT LAST
BIRTHDAY 35

(Years)

BIRTHPLACE

Bloomington, Ida.

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 12/14/25 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

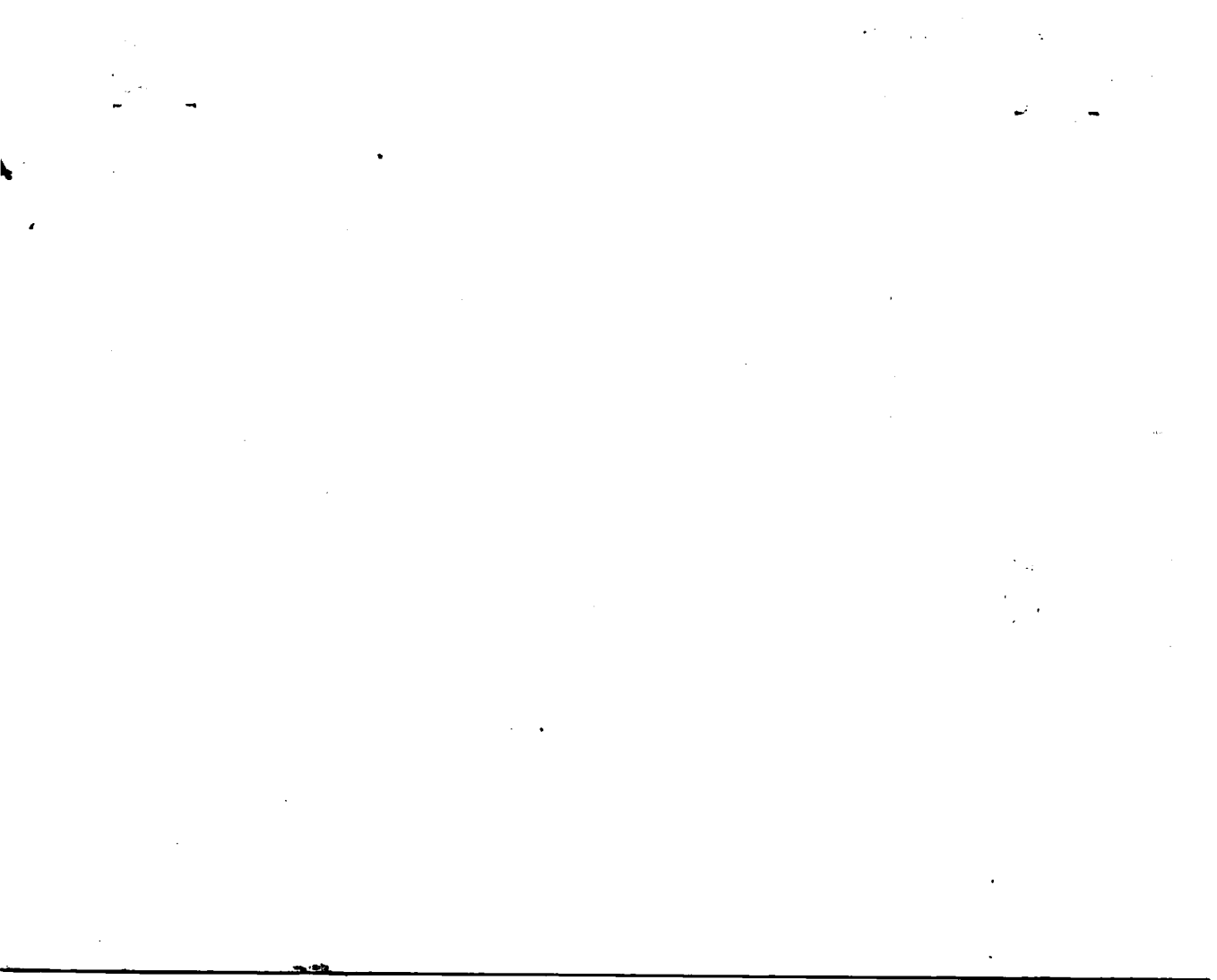
Cocatulle

Filed

1-7-1926

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

PLACE OF DEATH

JAN 19

CERTIFICATE OF DEATH

County of Bannock Registration District No. 28

City of Paratello Primary Registration District No. 2141

State File No. 51966

Local Registrar's No. 4712

(No. 544 - to Arthur)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Brian

(a) Residence. No. 544 - to Arthur St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) December 14 - 1925

7 AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) Stillborn
(c) Name of employer

9 BIRTHPLACE (city or town) Paratello
(State or country) Idaho

10 NAME OF FATHER W. J. Brian

11 BIRTHPLACE OF FATHER (city or town) Salt Lake City, Utah.
(State or country)

12 MAIDEN NAME OF MOTHER Paul Long

13 BIRTHPLACE OF MOTHER (city or town) Shoemonger Idaho.
(State or country)

14 Informant W. J. Brian
(Address) Paratello

15 Filed 1/14, 1925 Registrar R. J. [Signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 14 1925
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12/14/25 to 12/14/25 1925
that I last saw him alive on 12/14/25 1925
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Still Born - Due to placenta previa & prolapsing cord
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Call M. D.
(Signed) 1/14, 1925 (Address) Paratello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Bur Date of Burial Dec 14 1925

20. Undertaker Shumacher & Hall Address Paratello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

715 121 200 355
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham
City of Shelley

RECEIVED

FEB 8

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 121 State File No. 138045

Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 5

FULL NAME OF CHILD Jessie D. G. Giddings

(Certificate has no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Oct. 21 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Salt water

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Jesse Giddings
RESIDENCE Shelley
COLOR W AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Belle Temple
RESIDENCE Shelley, Ida
COLOR W AGE AT LAST BIRTHDAY 29
(Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 345 9 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

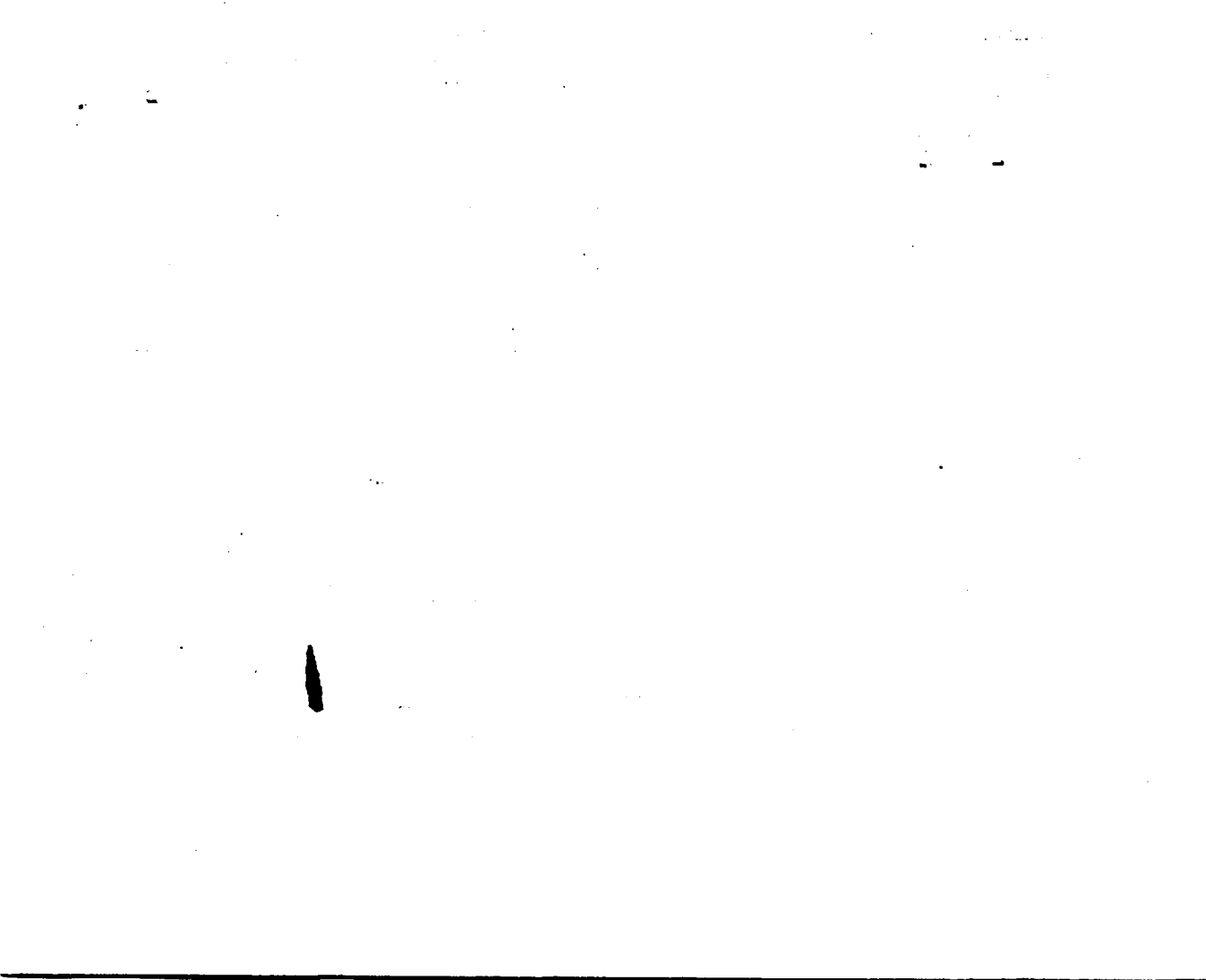
(Signature)

Address

Filed

Registrar.

Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **51665**Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. _____
County of Big Horn Primary Registration District No. _____
City of Shoshone (Write the word.) _____ St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jesse E. Gettrup

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)6. DATE OF BIRTH Dec 20 1924
(Month) (Day) (Year)7. AGE Born dead 12 LESS than 1 day
How many _____ hrs. _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Infant
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Jesse E. Gettrup

11. BIRTHPLACE OF FATHER

(State or Country) Wash

12. MAIDEN NAME OF MOTHER

Belle Peoples

13. BIRTHPLACE OF MOTHER

(State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse Gettrup
(Address) Shelly, Route 1

15. Filled _____ 19 _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Born dead 25
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____ to _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:Born dead
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)(Signed) F. E. Roberts M. D.
(Address) Shelly, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Shoshone Cemetery

DATE OF BURIAL

Dec 21 1925

20. UNDERTAKER

MM

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

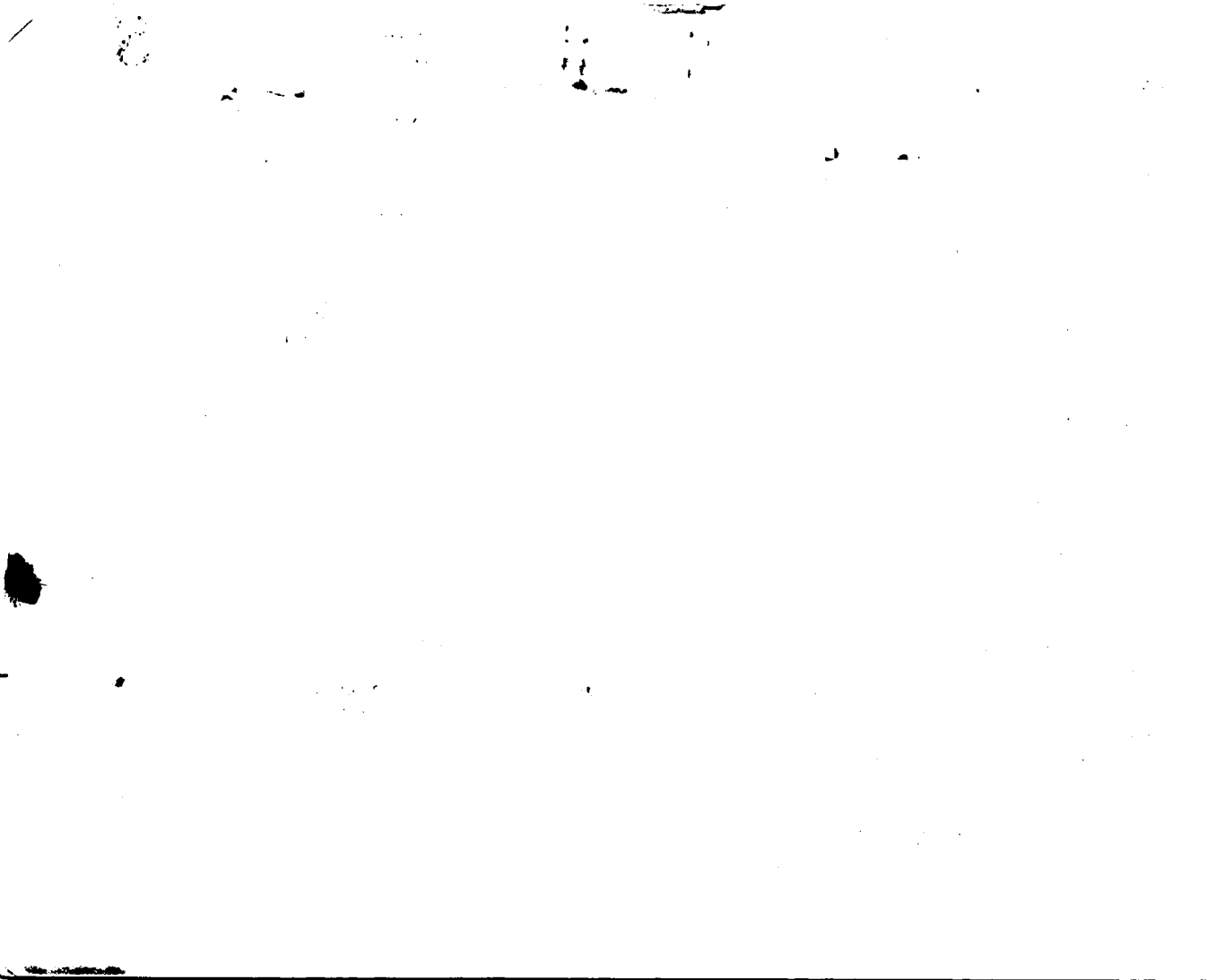
STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED		STATE OF IDAHO		S
253-123019-491		JAN 22		DEPARTMENT OF PUBLIC WELFARE		
County of		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		138114
City of		STATISTICS		CERTIFICATE OF BIRTH		
No.		St.		Registration District No. 76		State File No. 371
Hospital		Primary		Registration District No. 2153		Local Registrar's No.
FULL NAME OF CHILD <u>Stillborn</u> (Certificate of no value without full name of child)						
Sex of Child	Twin Triplet or other?	and { Number in order of birth		Legiti- mate?	Date of birth	
<u>Male</u>				<u>Yes</u>	<u>12 25 1925</u> (Month) (Day) (Year)	
What bactericidal solution was used in eyes? <u>None</u>						
Number of child of this mother, including present birth <u>3</u>				Number of child of this mother now living, including present birth <u>2</u>		
FULL NAME FATHER <u>Arthur Beck</u>				FULL MAIDEN NAME MOTHER <u>Maud Diamond</u>		
RESIDENCE <u>Worship</u>				RESIDENCE <u>Worship</u>		
COLOR <u>W</u>		AGE AT LAST BIRTHDAY <u>31</u> (Years)		COLOR <u>W</u>		AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Germany</u>				BIRTHPLACE <u>Utah</u>		
OCCUPATION <u>Laborer</u>				OCCUPATION <u>W. W.</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.						
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>430</u> <u>a</u> M. on the date above stated.						
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.						
Give names added from a supplemental report.						
, 192						
Registral.				Address		
Filed				Jan 19 1926 <u>Re Nowacki</u> Registral.		



RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of ButteCity of Mackay

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

not namedFile No. 52046Registered No. 52046

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male whiteChild
(Write the word.)

6. DATE OF BIRTH

Dec. 12
(Month)

(Day)

1925
(Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mackay, Idaho

10. NAME OF FATHER

Arthur Beck

11. BIRTHPLACE OF FATHER

(State or Country)

Perman

12. MAIDEN NAME OF MOTHER

Maud Diamond

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Beck

(Address)

Mackay, Idaho

15. FILED

Jan 19 1926
Rock Klowack
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 12
(Month)

(Day)

1925
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him, alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

P. A. Beck

M. D.

19

(Address)

Mackay, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

In the

days

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

814 130012-795
PLACE OF BIRTH

County of Butte

City of Moore

No. - St. -

Hospital -

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth

Legiti-
mate? Yes

Date of
birth June 30 1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes? No

Number of child of this mother, including present birth 5

Number of child of this mother now living, including present birth 3

FULL NAME FATHER W.E. Hammond

RESIDENCE Moore Ida.

COLOR White

BIRTHPLACE Wyo.

OCCUPATION Labour

FULL MAIDEN NAME MOTHER Merle Green

RESIDENCE Moore Ida.

COLOR White

BIRTHPLACE Utah

OCCUPATION Home wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

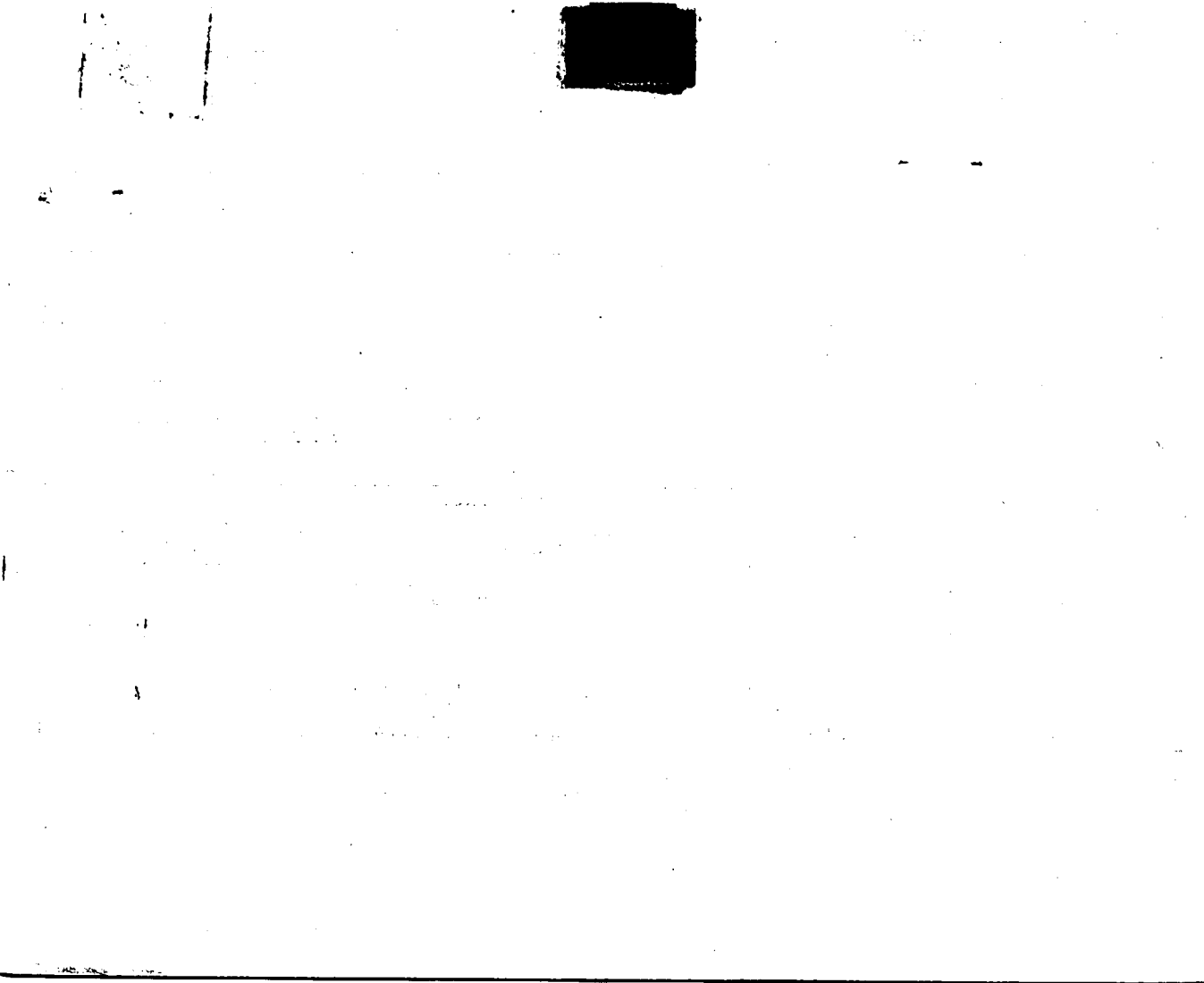
(Signature) M. J. Small

(Physician or midwife)
Address Moore Ida.

Filed Jan. 14 1926 Rep. Narvaich

Registrar.

Registrar.



FORM V. S. No. 5-A-25 M. 1-19.

RECEIVED

JAN 22

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BattleCity of Moore

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

Registration District No. 76
Statistical District No. 2153
(No. _____ St.)File No. 52045
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

Jan - 30 1925
(Month) (Day) (Year)

7. AGE

Stillborn
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Moore - Idaho

10. NAME OF FATHER

W. E. Hammond

11. BIRTHPLACE OF FATHER

(State or Country) Wyoming

12. MAIDEN NAME OF MOTHER

Merle Green

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Hammond(Address) Moore - Idaho

15.

Filed Jan. 19 1926 Ree Newach
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 30 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____ to 19____
that I last saw h. _____ alive on 19____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. E. Jensen M. D.19____ (Address) Brookway Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether (Accidental, Suicidal or Homicidal).

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

386-123066-796

RECEIVED
JAN 14

CERTIFICATE OF BIRTH

138174

County of CassiaCity of Burley

No. _____ St. _____

Registration District No. 117

File No. _____

Hospital _____

Primary Registration District No. 2196Registered No. 3280

FULL NAME OF CHILD

Baby Thompson

(Certificate of no value without full name of child.)

Sex of Child MaleTwin
Triplet
or other? —and
Number
in order
of birth —Legiti-
mate? YesDate of
birth Dec 23

1925

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? Ag NozNumber of child of this mother, including present birth 4Number of child of this mother now living, including present birth 2FULL
NAME

FATHER

C. Oral ThuesenFULL
MAIDEN
NAME

MOTHER

Laura L Grover

RESIDENCE

Burley

RESIDENCE

Burley

COLOR

WhiteAGE AT LAST
BIRTHDAY27

(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY27

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Ida

OCCUPATION

Labourer

OCCUPATION

Mother

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was
on the date above stated.born Dec 23 at 11 9 M.
(Born alive or stillborn)*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. H. CarterM.D.
(Physician or midwife)

Give names added from a supplemental report.

Address

Burley Ida

Filed

1-1 1926D. J. C. Patterson
Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

8

2000

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Cassia
City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATHRegistration District No. 117BUREAU OF VITAL STATISTICS
Registration District No. 2196

(No. _____ St.)

Stillborn ThuesenSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 52030Local Registrar's No. 878

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Dec 23 1925
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1
day how many
____ hrs. or
____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Burley, Ida

10. NAME OF FATHER

C. Oral Thuesen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Laura L. Grover

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Copied from birth certificate

(Address)

15.

Filed 1-1 1926 H. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 23 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Stillborn 19 to 19,that I last saw him alive on 19,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

StillbornPremature

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) L. H. Cutler M. D.12/23/25 (Address) Burley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted
if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida

DATE OF BURIAL

Dec 23 1925

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

386-103024 253

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED STATE OF IDAHO
BUREAU OF VITAL STATISTICS
JAN 1925
CERTIFICATE OF BIRTH

S138230

County of GoodingCity of HagermanRegistration District No. 21

File No. _____

No. _____ St. _____

Primary Registration District No. _____

Registered No. _____

Hospital _____

FULL NAME OF CHILD

Don Thorsted

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>yes</u>	Date of Birth <u>Oct 3</u> (Month) (Day) (Year) <u>1925</u>
--------------------------	---	-----	---	----------------------------	---

FATHER FULL NAME <u>R L Thorsted</u>	MOTHER FULL MAIDEN NAME <u>Grace Beltz</u>
RESIDENCE <u>Hagerman</u>	RESIDENCE <u>Hagerman</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>43</u> (Years)	AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Ill</u>
OCCUPATION <u>merchant</u>	OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth <u>9</u>	Number of children of this mother now living, including present birth <u>8</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born, at 8 AM M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R R Greene

(Physician or midwife)

Given names added from a supplemental report.

19

Address HagermanFiled Oct 10 1925 - R R Greene

Registrar

Registrar

2

1. PLACE OF DEATH

County of Gooding
City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Don Thorsted

CERTIFICATE OF DEATH

RECEIVED
JAN 18Registration District No. 21
Registration District No. 21
No. 52068State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 52068
Registered No. 1898

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)6. DATE OF BIRTH Oct 3 1925
(Month) (Day) (Year)7. AGE Still Born IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

R L Thorsted

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Grace Beltz

13. BIRTHPLACE OF MOTHER

(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R L Thorsted
Hagerman15. Filed Oct 3 1925 R N Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 3 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1925 Still Born that I last saw him alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Loup in cord
shutting off circulation
Duration Yrs. mos. ds.
Contributor
(Secondary) before birth
(Duration) Yrs. mos. ds.(Signed) R N Greene M. D.Oct 3 1925 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Rt

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerman Dec 3 1925
20. UNDERTAKER None ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

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STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai
City of Ellettsville
No. 551180028395 St. Registration No. 3 State File No. 138299
RECEIVED FEB 10 1926 BUREAU OF VITAL STATISTICS
Hospital _____ Primary Registration District No. 1051 Local Registrar's No. 1480
FULL NAME OF CHILD (unnamed) Evans
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? Yes Date of birth Dec. 30. 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, excluding present birth 0

FATHER		MOTHER	
FULL NAME	<u>Harold J. Evans</u>	FULL MAIDEN NAME	<u>Laura C. Cross</u>
RESIDENCE	<u>Rathdrum, Ida.</u>	RESIDENCE	<u>Rathdrum, Ida.</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>22</u> (Years)	AGE AT LAST BIRTHDAY	<u>30</u> (Years)
BIRTHPLACE	<u>Mont.</u>	BIRTHPLACE	<u>Mont.</u>
OCCUPATION	<u>Schoolteacher</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at S. E. P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

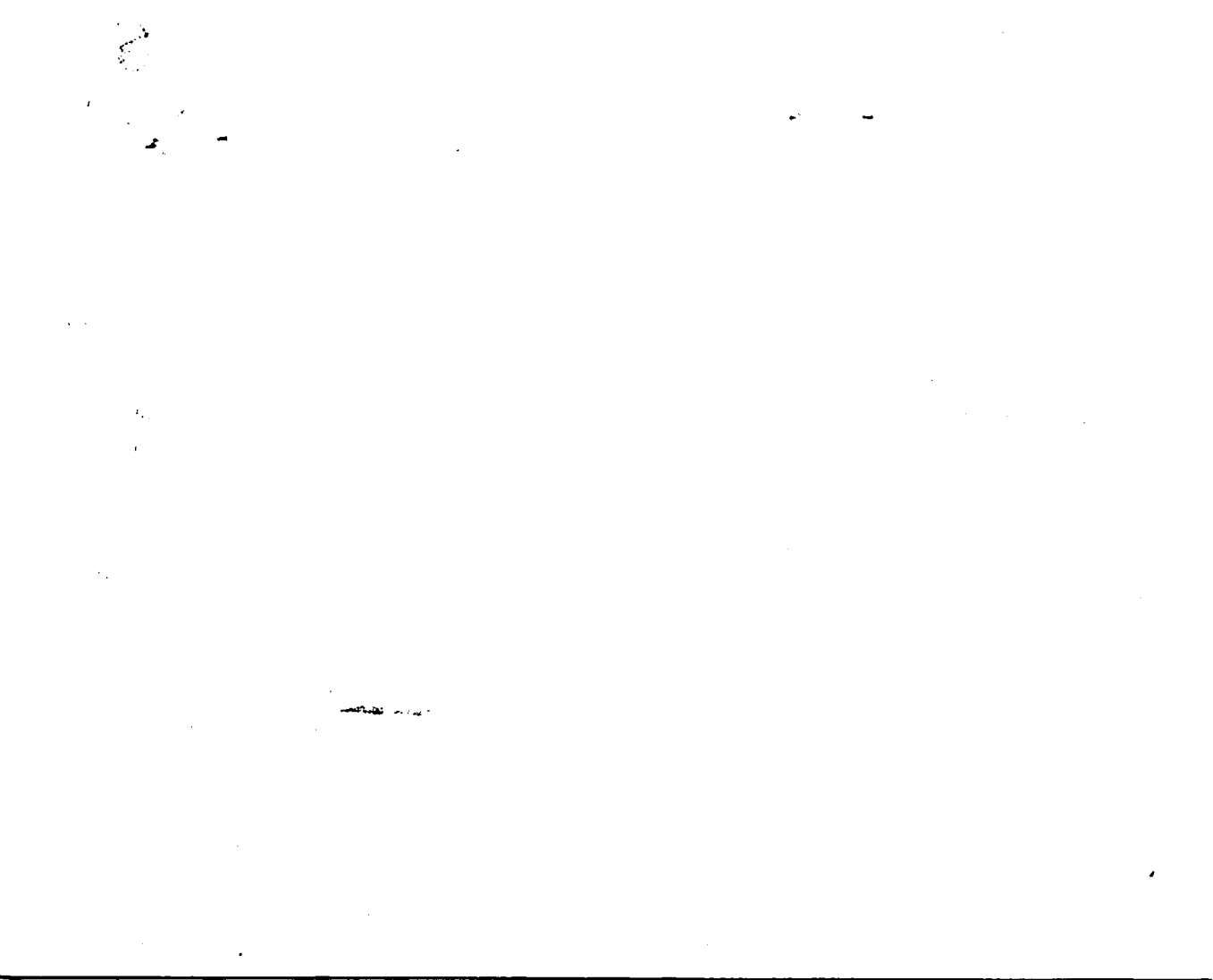
(Signature) Frank H. Keng
Physician
(Physician, or midwife)

Address Rathdrum, Ida.

Filed Feb 6 1926 J. D. Dreiman

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **51801**

PLACE OF DEATH RECEIVED CERTIFICATE OF DEATH

County of Boone JAN 7 Registration District No. 30

City of Ratholm BUREAU OF VITAL STATISTICS Registration District No. 1051

Local Registrar's No. 1404

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold James Evans Jr.

(a) Residence. No. St. Ratholm, Ida.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single - Stillborn

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 30, 1925

7 AGE

Years

Months

Days

If LESS than

1 day, _____ hrs.

or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

—

(c) Name of employer

9 BIRTHPLACE (city or town) Ratholm, Ida.
(State or country)

10 NAME OF FATHER Harold J. Evans

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Wicks - Mont.

12 MAIDEN NAME OF MOTHER Laura C. Gress

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Kinsal
N. Dak.

14 Informant Harold J. Evans
(Address) Ratholm, Ida.

15 Filed Aug 4, 1925 W.D. Danner
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 30, 1925
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec. 30, 1925, to Dec. 30, 1925

that I last saw him alive on Lewis Stillborn 19

and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Stillborn; Enlargement of
liver - 3 times normal size

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Frank Hengge, M. D.

12/31, 1925 (Address) Ratholm, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Evergreen Cem, Ratholm 12-31 1925

20 Undertaker Address

C. Cassidy CDalme

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

415-120-030-693
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

138325

S

County of Lewia
City of Carmen
No. 41 District No. 2116 State File No. 138325
Hospital _____ Primary Registration District No. 2116 Local Registrar's No. _____
FULL NAME OF CHILD Premature 5 month infant

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? _____ } and { Number in order of birth _____ Legiti- mate? yes Date of birth Dec 20 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Bert Daurels
RESIDENCE Carmen
COLOR wh AGE AT LAST BIRTHDAY 52
(Years)
BIRTHPLACE Wise
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Nellie Wittenburg
RESIDENCE Carmen
COLOR wh AGE AT LAST BIRTHDAY 39
(Years)
BIRTHPLACE Iowa
OCCUPATION Hom

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn? at 9 30 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 1925

(Signature) [Signature]

(Physician or midwife)

Address Salmon

Filed Jan 10 1926

Registrar.

Registrar.

MD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

819 171-035-319
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

JAN 13

CERTIFICATE OF BIRTH 38364

County of Nez Perce
City of Lewiston
No. 96 St. St. Joseph Registration District No. 1009 File No. 1009
Hospital St. Joseph Primary Registration District No. 1009 Registered No. 1009
FULL NAME OF CHILD Ernest M. Harrison

(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin Triplet or other? <u>X</u> and Number in order of birth <u>X</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 21</u> 192 <u>5</u> (Month) (Day) (Year)
------------------------	---	------------------------	--

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME <u>Ernest M. Harrison</u>	FULL MAIDEN NAME <u>Twins A. Lamps</u>	FULL NAME <u>Twins A. Lamps</u>	FULL MAIDEN NAME <u>Twins A. Lamps</u>
RESIDENCE <u>Clarkston Wash</u>	RESIDENCE <u>Clarkston Wash</u>	RESIDENCE <u>Clarkston Wash</u>	RESIDENCE <u>Clarkston Wash</u>
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Canada</u>	BIRTHPLACE <u>Canada</u>
OCCUPATION <u>laborer</u>	OCCUPATION <u>laborer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at Idaho on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. H. H. H. H. H.

Physician (Physician or midwife)

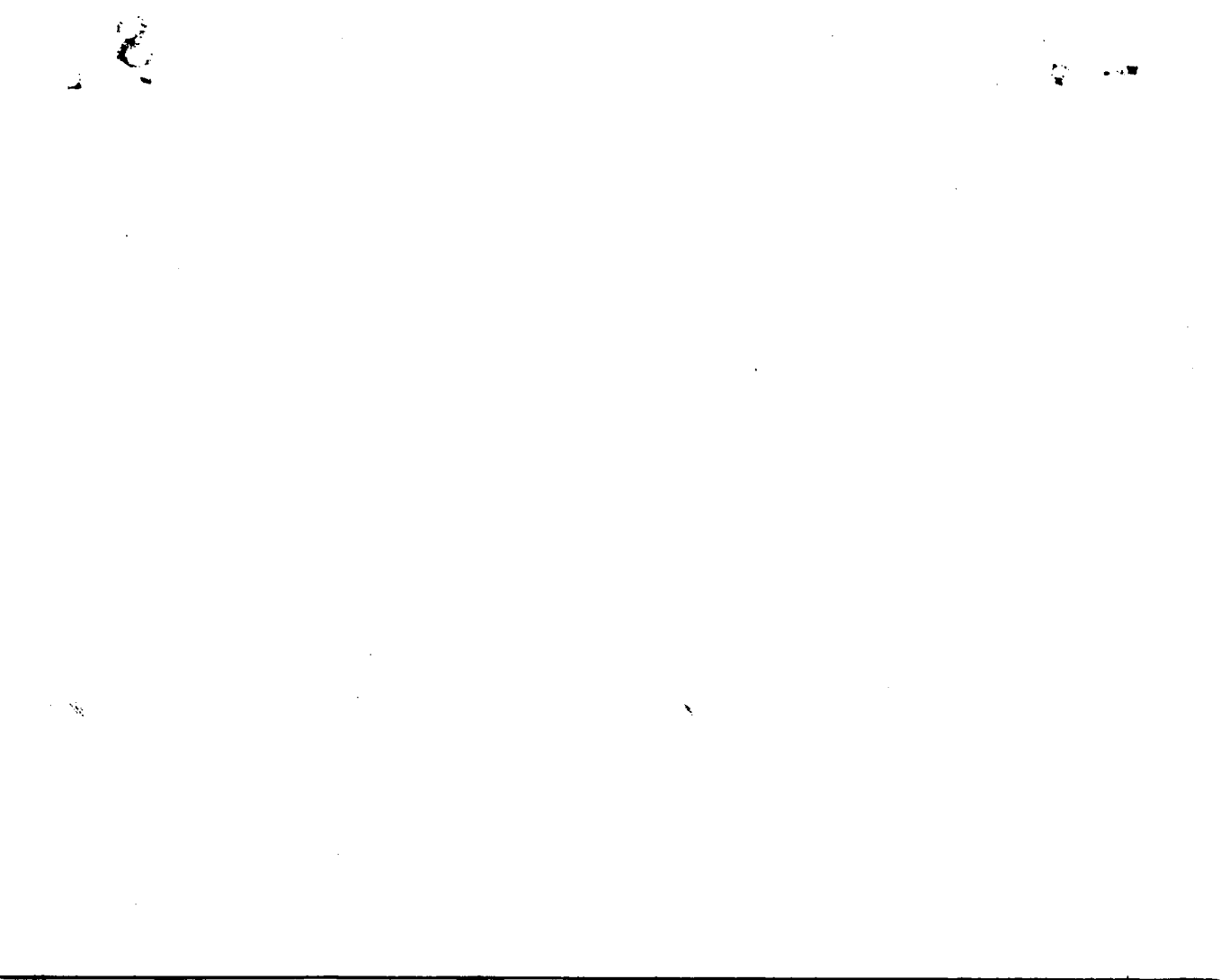
Give names added from a supplemental report.

Address Lewiston Idaho

Filed Jan 8 1926 Marion E. Bruce

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Adair Registration District No. 96
City of Lewiston Primary Registration District No. 1009
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Harrison

State File No. 52152
Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

Dec 22 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant9. BIRTHPLACE
(State or Country)Idaho

10. NAME OF FATHER

E. M. Harrison11. BIRTHPLACE OF FATHER
(State or Country)Idaho

12. MAIDEN NAME OF MOTHER

Lewis Lane13. BIRTHPLACE OF MOTHER
(State or Country)Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. M. Harrison

(Address)

Lewiston, Ida

15.

Filed

Jan 6 19261926Wm E. Bruen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1925 to Dec 22 1925

that I last saw alive on Dec 22 1925, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum
Stillborn

(Duration) yrs. mos. ds.

Contributory (Secondary)

Malapex of Cord

(Duration) yrs. mos. ds.

(Signed)

L. B. Hastings

M. D.

12/22/25 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida12/23 1925

20. UNDERTAKER

ADDRESS

Brown-Hamm Co.Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 316-110 40-221
County of Shoshone
City of Wallace
RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
JAN 16
CERTIFICATE OF BIRTH
No. _____ St. Registral District No. 70 State File No. 138439
Hospital Providence Primary Registration District No. 104 Local Registrar's No. 206
FULL NAME OF CHILD Still Born

(Certificate of no value without full name of child)

Sex of Child M Twin Triplet or other? 1 and { Number in order of birth 1 } Legitimate? Yes Date of birth 10-10 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME Norton La Fone
RESIDENCE Murray Idaho
COLOR White AGE AT LAST BIRTHDAY 45 (Years)
BIRTHPLACE Missouri
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Anna Skahsky
RESIDENCE Murray Idaho
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 a. m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1925

(Signature) D. B. Mowery
D. B. Mowery
(Physician or midwife)

Address Wallace Idaho

Filed Dec 15 1925 J. B. Binkley
Registrar.

Registrar.

GENERAL STATE OF IOWA
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

STATE OF IOWA
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____
 City of _____
 County of _____
 Hospital _____
 Date of Birth _____
 Sex of Child _____
 (To be used only in case of stillbirth)

What antiseptical solution was used in case _____
 Name of child at birth, including present birth _____
 Name of mother _____
 Name of father _____
 Residence _____
 Color _____
 Age at last birthday _____
 Birthplace _____
 Occupation _____
 Birthplace _____
 Color _____
 Age at last birthday _____
 Residence _____
 Name of mother _____
 Name of father _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 (Signature) _____
 (Physician or midwife)
 Address _____
 Filed _____
 Date _____

Give names added from a supplemental report.
 *When there was no attending physician or midwife, the father, householder, or other person present at the birth, or who should make the return, a certificate should be made that neither physician nor midwife was present at the birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Shoshone*
City of *Wallace*Registration District No. *70*Primary Registration District No. *101*State File No. *51879*Registrar's No. *125*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of M. B. Lafon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

Oct 10 1925
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

M. B. Lafon

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Anne E. Staliskey

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. B. Lafon

(Address)

Murray Idaho

15.

Filed *October 11* 19*25*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 10 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw *him* alive on 19and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. H. W. Wright

(Address)

Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Wallace Ida**Oct 11 1925*

20. UNDERTAKER

ADDRESS

*W. H. Martell**Wallace Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Shoshone

JAN 16

CERTIFICATE OF BIRTH

138442

City of Wallace

BUREAU OF

315223040389

No. Providence St.

Registration District No. 70

State File No.

Hospital Providence

Primary Registration District No. 1011

Local Registrar's No. 209

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of
Child

F

Twin
Triplet
or other?

1

and

Number
in order
of birth

1

Legiti-
mate?

Yes

Date of
birth

10-23

1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Dr. J. J. J.

Number of child of this mother, including present birth

4

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER
John Cavanaugh

FULL
MAIDEN
NAME

MOTHER
Allice Cyr

RESIDENCE

Wallace, Idaho

RESIDENCE

Wallace, Idaho

COLOR

W

AGE AT LAST
BIRTHDAY

36
(Years)

COLOR

W

AGE AT LAST
BIRTHDAY

3
(Years)

BIRTHPLACE

Pennsylvania

BIRTHPLACE

Montana

OCCUPATION

Laborer

OCCUPATION

House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7:45 A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Dr. J. J. J.

(Physician or midwife)

Address

Wallace, Idaho

Filed

Dec 15 1925

Geo. D. Dugley

Registrar.

THIS IS TO CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN AT THE PLACE AND DATE HEREIN SET FORTH IN THE PRESENCE OF THE REGISTRAR AND TWO OTHERS WHOSE NAMES ARE HEREIN SET FORTH.

PLACE OF BIRTH

County of

City of

State of

Registration District No.

FULL NAME OF CHILD

Sex

Color

Birthplace

Occupation

Age at birth

Residence

Color

Birthplace

Occupation

What antiseptical solution was used in birth

Signature of child of this mother, including nearest blood

FATHER

NAME

DATE

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

AGE AT BIRTH

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

FATHER

DATE

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

AGE AT BIRTH

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

AGE AT BIRTH

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

AGE AT BIRTH

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No.

County Registration District No.

Full name of child

Sex

Color

Birthplace

Occupation

Age at birth

Residence

Color

Birthplace

Occupation

Age at birth

Residence

Color

Birthplace

Occupation

Age at birth

Residence

Color

Birthplace

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was

(Name of child)

(Sex)

(Color)

(Birthplace)

(Occupation)

(Age at birth)

(Residence)

(Color)

(Birthplace)

(Occupation)

(Age at birth)

(Residence)

(Color)

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(Color)

(Birthplace)

(Occupation)

(Age at birth)

(Residence)

(Color)

(Birthplace)

(Occupation)

FORM V. S. No. 5, 25 M. 1-19.

1. PLACE OF DEATH

County

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 70

Registration District No. 110

(No.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

51885

State File No.

Local Registrar's No. 112

If death occurred in a hospital institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1925

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw him alive on 19 and that death occurred on the date stated above, at 89 M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds. Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

231-228044, 231
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Washington **RECEIVED**
City of Wenatchee JAN 13 1 CERTIFICATE OF BIRTH 138522
No. 56 St. Registration District No. File No.
Hospital Primary Registration District No. 1010. Registered No. 41

FULL NAME OF CHILD

still born

(Certificate of no value without full name of child.)

Sex of Child <u>Girl</u>	Twin Triplet or other? <u>and</u>	Number in order of birth	Legitimate? <u>No</u>	Date of Birth <u>11/28/1925</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME FATHER
Mr. J. J. J. J. J.

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL MAIDEN NAME MOTHER
Mrs. H. H. H. H. H.

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 3:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. H. H. H. H.

(Physician or midwife)

Give names added from a supplemental report.

Address Wenatchee, Idaho

Filed Jan 14 1926 H. H. H. H. H.

Registrar.

Registrar.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 86
 County of Washington JAN 13 Primary Registration District No. 1010
 City of Weiser ST. BUREAU St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Stanger

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 52250Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White S
 (Write the word.)

6. DATE OF BIRTH

Nov 28 1925
 (Month) (Day) (Year)

7. AGE

Stillborn
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Dont Know

11. BIRTHPLACE OF FATHER

(State or Country)

Illegitimate

12. MAIDEN NAME OF MOTHER

Muriel Stanger

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emmet Stanger
 (Address) Weiser Ida

15.

Filed Nov 29 1925

H. R. Haun

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 28 1925
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to 19.....
 that I last saw h..... alive on..... 19.....
 and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Still Born
due to prolaps of cord (umbilical)
 (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. T. Schmitt M. D.

Nov 29 (Address) Weiser, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hickory Cemetery 11-29-1925

20. UNDERTAKER

ADDRESS

Northam McLean Weiser Ida

AUG 07 2012

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH 636-125003863		STATE OF IDAHO	
County of <u>Danmark</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Bozelle</u>		BUREAU OF VITAL STATISTICS	
No. <u>St. Anthony's</u>		RECEIVED	
Hospital <u>650 No. 9th</u>		FEB 15	
Registration District No. <u>28</u>		CERTIFICATE OF BIRTH	
Primary Registration District No. <u>2161</u>		138650	
Local Registrar's No. <u>7406</u>			
FULL NAME OF CHILD <u>Stillborn</u>			
(Certificate of no value without full name of child)			
Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>
(To be answered only in event of plural births)		Date of birth <u>12/25</u> 192 <u>5</u>	
		(Month) (Day) (Year)	
What bactericidal solution was used in eyes? <u>Premature birth caused by febrile condition</u>			
Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>0</u>	
FULL NAME FATHER <u>Walter J. Olwein</u>		FULL MAIDEN NAME MOTHER <u>Alva C. Holmberg</u>	
RESIDENCE <u>622 So. 8th</u>		RESIDENCE <u>622 So. 8th</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Toledo, Ohio</u>		BIRTHPLACE <u>Newcastle Colo.</u>	
OCCUPATION <u>Butcher</u>		OCCUPATION <u>Housewife</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE			
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>4:00</u> P. M. on the date above stated.			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.			
Give names added from a supplemental report. <u> </u> , 192 <u> </u>			
(Signature) <u>A. M. Newton M.D.</u>		(Physician or midwife)	
Address <u>Bozelle</u>			
Filed <u>21</u> 192 <u>6</u>		Registrar.	
		Registrar.	

RECEIVED

County of _____
 State of _____
 City of _____
 No. _____
 Patient's Hospital No. _____
 Local Birthplace No. _____

(Certificate to be filled out by the attending physician)
 Name of child _____
 Sex _____
 Date of birth _____
 Place of birth _____
 (To be completed only in case of hospital birth)

Name of child of this mother now living, including present birth _____
 MOTHER
 FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHDAY _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____
 (Physician or Midwife)
 Address _____
 Signed _____
 Date _____
 *This certificate is not valid unless signed by the attending physician or midwife, and is subject to the provisions of the laws of the State of California, Chapter 10, Section 12, and Chapter 11, Section 12, of the Statutes of the State of California, 1907, and Chapter 10, Section 12, of the Statutes of the State of California, 1909.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

51977

State File No.

Local Registrar's No.

PLACE OF DEATH

RECEIVED

CERTIFICATE OF DEATH

County of Bannock Registration District No. 28City of Porter Primary Registration District No. 2161(If death occurred in a hospital or institution, give its name instead of street and number.)
(No. St. Anthony Hospital)2. FULL NAME Infant Oliver(a) Residence. No. 122 E 8th St.

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day and year) Dec 25 - 1925

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Porter
(State or country) Idaho10 NAME OF FATHER Walter11 BIRTHPLACE OF FATHER (city or town) Ohio
(State or country)12 MAIDEN NAME OF MOTHER Alma Holmberg13 BIRTHPLACE OF MOTHER (city or town) Colorado
(State or country)14 Informant Walter Oliver
(Address) Porter15 Filed 1/26, 1925 J. J. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 25 1925
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1925, to Dec 25, 1925, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Still birth premature probably caused by fibrosis of uterus

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death? _____Did an operation precede death? m Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) A. M. Newton M. D.Dec 26, 1925 (Address) Porter, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Mountain View Bur Dec 27 1925

20. Undertaker Address

Shumacher & Hall Porter

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of

City of

No. 793-208006 13/31

Registration District No. 986

State File No.

Hospital

Primary Registration District No. 2176

Local Registrar's No. 5

138999

CERTIFICATE OF BIRTH

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other?

}

and {

Number
in order
of birth

}

Legiti-
mate?

Yes

Date of
birth

12/8

1925

(Month) (Day)

(Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

0

FULL
NAMEFATHER
Ralph GellFULL
MAIDEN
NAMEMOTHER
Gladys Stater

RESIDENCE

Rexley

RESIDENCE

Rexley

COLOR

White

AGE AT LAST
BIRTHDAY

21

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

20

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Laborer

OCCUPATION

Homemaker

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 57 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

Thos. S. Moody

(Physician or midwife)

Address

Rexley, Idaho

Filed

Mar 10th 1926

Ray H. Fisher

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Seven or eight months pregnancy
and child was born, being
a breech presentation on arrival
but before I reached the
bedside.

28 M

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

MAR 8

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 52475

Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

17/19/26

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

"BLUE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated."

234 204 028-464

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of Mont.

City of Boise

No. 1497

Registration District No. 30

State File No. 139028

Hospital

Primary Registration District No. 051

Local Registrar's No. 1497

FULL NAME OF CHILD

Not named.

(Certificate of no value without full name of child)

Sex of
Child

fe.

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes.

Date of
birth

Oct. 4.

1925

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

no

Number of child of this mother, including present birth

1 Number of child of this mother now living, including present birth

FULL
NAME

FATHER

J. H. Sturges

RESIDENCE

Idaho

COLOR

Wh.

AGE AT LAST
BIRTHDAY

21

(Years)

BIRTHPLACE

Arizona

OCCUPATION

P. T. S.

FULL
MAIDEN
NAME

Violet E. Rodding

RESIDENCE

Idaho

COLOR

Wh.

AGE AT LAST
BIRTHDAY

31

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housew.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8 a. 8 M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 1925

(Signature)

J. H. Sturges

(Physician or midwife)

Address

Coeur d'Alene, Ida.

Filed

Feb 5 1926

W. D. Dorman

Registrar.

Registrar.

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF IOWA

2

County of Polk
City of Des Moines
Hospital St. Luke's
Primary Registration District No. 22A Local Registration District No. 1 State File No. 139058

NAME OF CHILD John Edward
(Certificate of no value without full name of child)

Sex of child Male Date of birth May 10 1917
Month (Day) (Year) 1917
Place of birth Des Moines, Iowa
(To be answered only in event of birth abroad)

Registration number was used in event of no
Name of mother John Edward
Name of father John Edward

Full name of mother John Edward
Full name of father John Edward
Name John Edward

Residence Des Moines, Iowa
Color White
Age at last birthday 31 (Years)

Birthplace Des Moines, Iowa
Occupation None

Occupation None
Birthplace Des Moines, Iowa

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born
(Signature) John Edward

(Physician or midwife)
Address Des Moines, Iowa
Signed John Edward
Date May 10 1917

Give names added from a supplemental report.
Knows other evidence of the birth.
Child is one that mother practices not
to attend make this report. A midwife
or other than the latter, however,
when there was no attending physician
as the date above stated.

Registrar

... every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
PLACE OF DEATH **RECEIVED**
MAY 8 1926
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **52492**

County of _____
City of _____
Registration District No. **30**
Primary Registration District No. **1051**

Local Registrar's No. **1768**

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____ St.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **M** 4 COLOR OR RACE **W** 5 Single, Married, Widowed, or Divorced (write the word) **Single**

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days 1 If LESS than day, hrs. or min. **stillborn**

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) **Idaho**

10 NAME OF FATHER **J H Sturges**

11 BIRTHPLACE OF FATHER (city or town) (State or country) **Arizona**

12 MAIDEN NAME OF MOTHER **Violet C Blodig**

13 BIRTHPLACE OF MOTHER (city or town) (State or country) **Idaho**

14 Informant **J H Sturges**
(Address) **Corn & Allen**

15 Filed _____, 19____ **D D Drama**
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **Oct 4** 19 **25**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
that I last saw h. _____ alive on **stillborn** _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Stillborn
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) **Hostage**
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) **J H Sturges** M. D.
Oct 1, 19 **26** (Address) **Corn & Allen**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal **Cremation** Date of Burial **Oct 4** 19 **26**
20. Undertaker **None** Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

281 106-038 497
PLACE OF BIRTH

Form V. S. No. 11--20m-7-30-19

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

MAR 4

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTHCounty of Payette

City of _____

Registration District No. 4

File No.

139167

No. _____ St. _____

Primary Registration District No. 1008Registered No. 11

Hospital _____

FULL NAME OF CHILD Unmarried

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of Birth (Month) <u>Sept 6</u> (Day) <u>1925</u> (Year)
--------------------------	---	-----	---	-----------------------------	---

FULL NAME <u>Rodney L. Blake</u>	FATHER
RESIDENCE <u>Three miles South of Fruitland Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>3/</u> (Years)
BIRTHPLACE <u>Minnesota</u>	
OCCUPATION <u>Farming</u>	

FULL MAIDEN NAME <u>Julia Dixon</u>	MOTHER
RESIDENCE <u>Three miles South of Fruitland Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>3/</u> (Years)
BIRTHPLACE <u>Illinois</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born at 9:00 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

C. H. AveryPhysician
(Physician for midwife)

Given names added from a supplemental report.

19

Address

Payette, Ida

Filed

Feb 27 1926 J. C. Woodward
Registrar.

Registrar.

170P

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
MAR 13
BUREAU OF VITAL
STATISTICS

S

140030

County of Jefferson
City of Payson
No. 365-221-026-813 State File No. 106
Hospital _____ Primary Registration District No. 478 Local Registrar's No. 1378

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 22</u> 192 <u>5</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>3</u>		Number of child of this mother now living, including present birth <u>2</u>	
FATHER		MOTHER	
FULL NAME <u>Clarence Love</u>	FULL MAIDEN NAME <u>Florence May Hale</u>		
RESIDENCE <u>Payson R#3</u>	RESIDENCE <u>Payson R#3</u>		
COLOR <u>W.</u>	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Kaysville, Utah</u>	BIRTHPLACE <u>Idaho Falls, Idaho</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn Dead alive Alive M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. R. Rigby M.D.

(Physician or midwife)

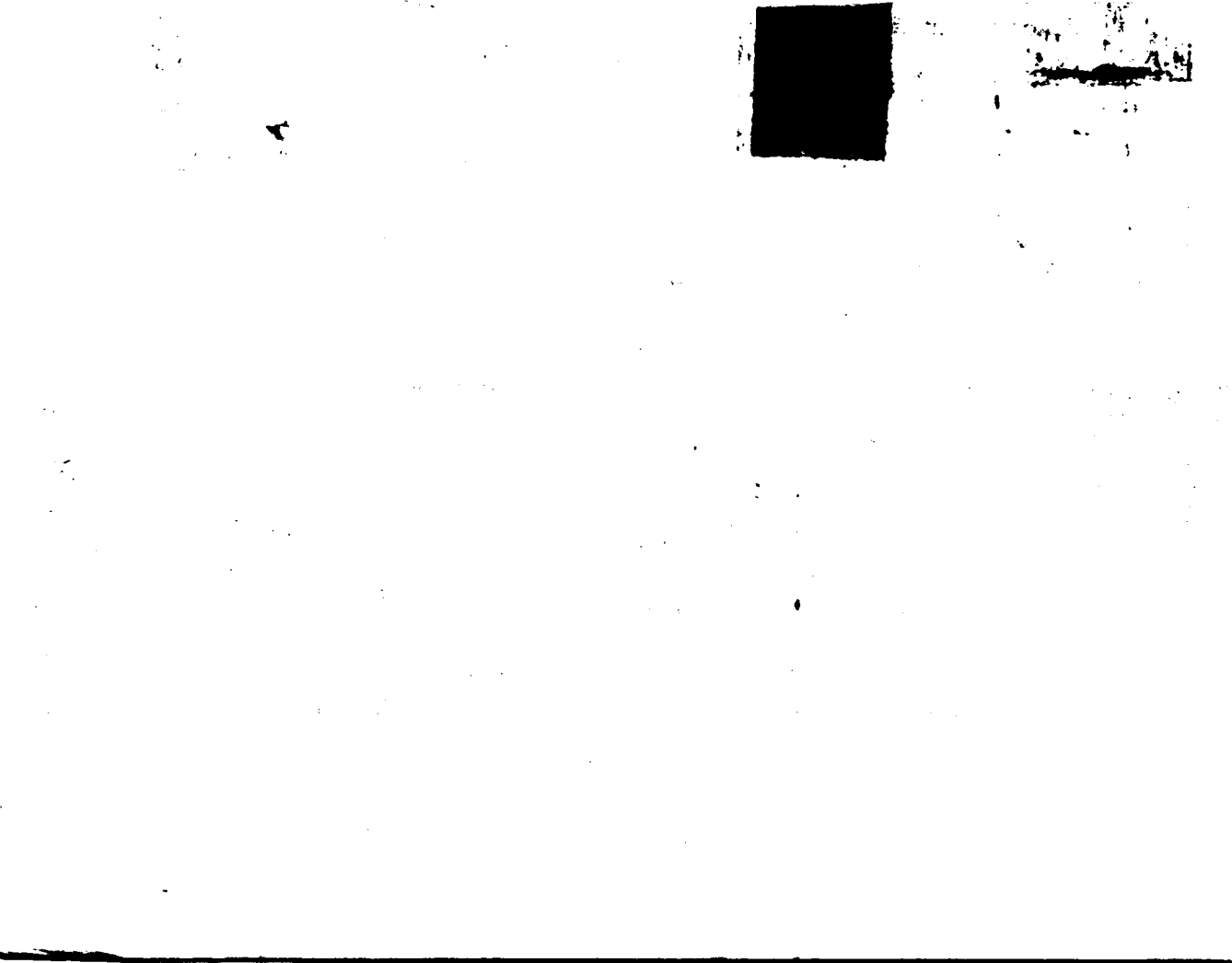
Give names added from a supplemental report.

Address _____

Filed 3/10 1926

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

864 107 026 155
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
JUN 28 1926

S

County of Jefferson
City of Hamm
No. 98 St. 2176
Hospital 97
Registration District No. 98 File No. 142446
Primary Registration District No. 2176 Registered No. 97

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child MA Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth 10 7 1925
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER	MOTHER
FULL NAME <u>Ray Young</u>	FULL MAIDEN NAME <u>Lona Young</u>
RESIDENCE <u>Hamm</u>	RESIDENCE <u>Hamm</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>21</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Ida</u>	BIRTHPLACE <u>Ida</u>
OCCUPATION <u>O.S.L. Section Lab</u>	OCCUPATION <u>House</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

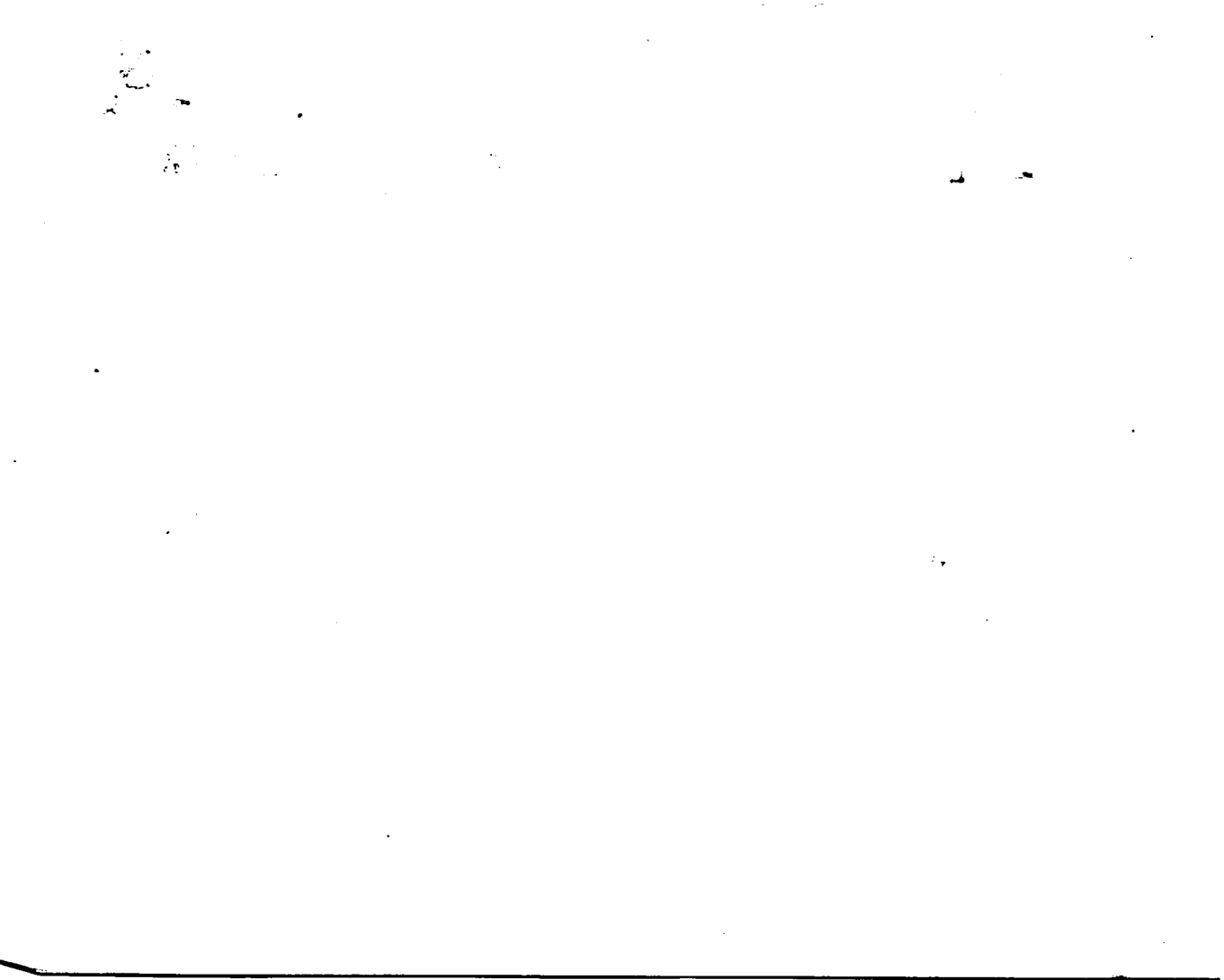
I hereby certify that I attended the birth of this child, who was Suckorn at 130 A M.
on the date above stated. (Born alive or stillborn)

{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature) East D. Young

(Physician or midwife)

Give names added from a supplemental report. Robert
Address Ray H. Fisher
1926 Filed 6/10 1926 6
Registrar. Ray H. Fisher Registrar.



1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

RECEIVED
JUN 28 1926
BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

53931

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to

19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Duration)

Yrs.

mos.

ds.

(Address)

19.....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

295-227-028-613

PLACE OF BIRTH

RECEIVED

OCT 30 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH **142560**

County of

City of

No. St.

Registration District No.

File No.

Hospital

Primary Registration District No.

Registered No.

FULL NAME OF CHILD

Stillbirth

(Certificate of no value without full name of child.)

Sex of Child <i>M</i>	Twin Triplet or other? <i> }</i>	and {	Number in order of birth	Legitimate? <i>yes</i>	Date of birth <i>Jan 27</i> 192 <i>5</i>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? *L*Number of child of this mother, including present birth *5* Number of children of this mother now living, including present birth *4*

FATHER	MOTHER
FULL NAME <i>Leonard Brent</i>	FULL MAIDEN NAME <i>Lilly Wallen</i>
RESIDENCE <i>Black Lake Ida</i>	RESIDENCE <i>Black Lake Ida</i>
COLOR <i>White</i>	COLOR <i>White</i>
AGE AT LAST BIRTHDAY <i>32</i> (Years)	AGE AT LAST BIRTHDAY <i>27</i> (Years)
BIRTHPLACE <i>B.C.</i>	BIRTHPLACE <i>Ontario</i>
OCCUPATION <i>Logger</i>	OCCUPATION <i>Ontario Hw.</i>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Stillborn*, at *8 45 P* M. on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Karl J. May M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Harrison Ida
W. D. Burrell
Idaho Registrar.Filed *✓*

192

192

CERTIFICATE OF BIRTH

County of _____
 City of _____
 Registration District No. _____
 Primary Registration District No. _____
 Hospital _____

FULL NAME OF CHILD

Sex of Child _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____
 Name of Mother _____
 Name of Father _____

What protective action was used in case of _____
 Number of child of this mother including _____
 Name of child of this mother including _____

NAME	FATHER	MOTHER
COLOR	AGE AT LAST BIRTHDAY	COLOR
BIRTHPLACE	AGE AT LAST BIRTHDAY	BIRTHPLACE
OCCUPATION	OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 on the date above stated _____
 (Signature) _____
 (Physician or Midwife)

One name added from a supplemental report _____
 Filed _____
 A _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

437-128- RECEIVED OCT 1 1926
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

019-5950
County of Custer
City of Challis
No. _____ St. _____ Registration District No. 108 State File No. 145102
Hospital _____ Primary Registration District No. 2186 Local Registrar's No. 93
FULL NAME OF CHILD Unnamed
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date May 28 1925
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Arthur Mills McGowan
RESIDENCE Idaho
COLOR White AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Idaho
OCCUPATION Mechanic

MOTHER
FULL MAIDEN NAME Elma Rosella Niese
RESIDENCE Idaho
COLOR White AGE AT LAST BIRTHDAY 18
(Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:45 a M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) E. M. Kenney M.D.

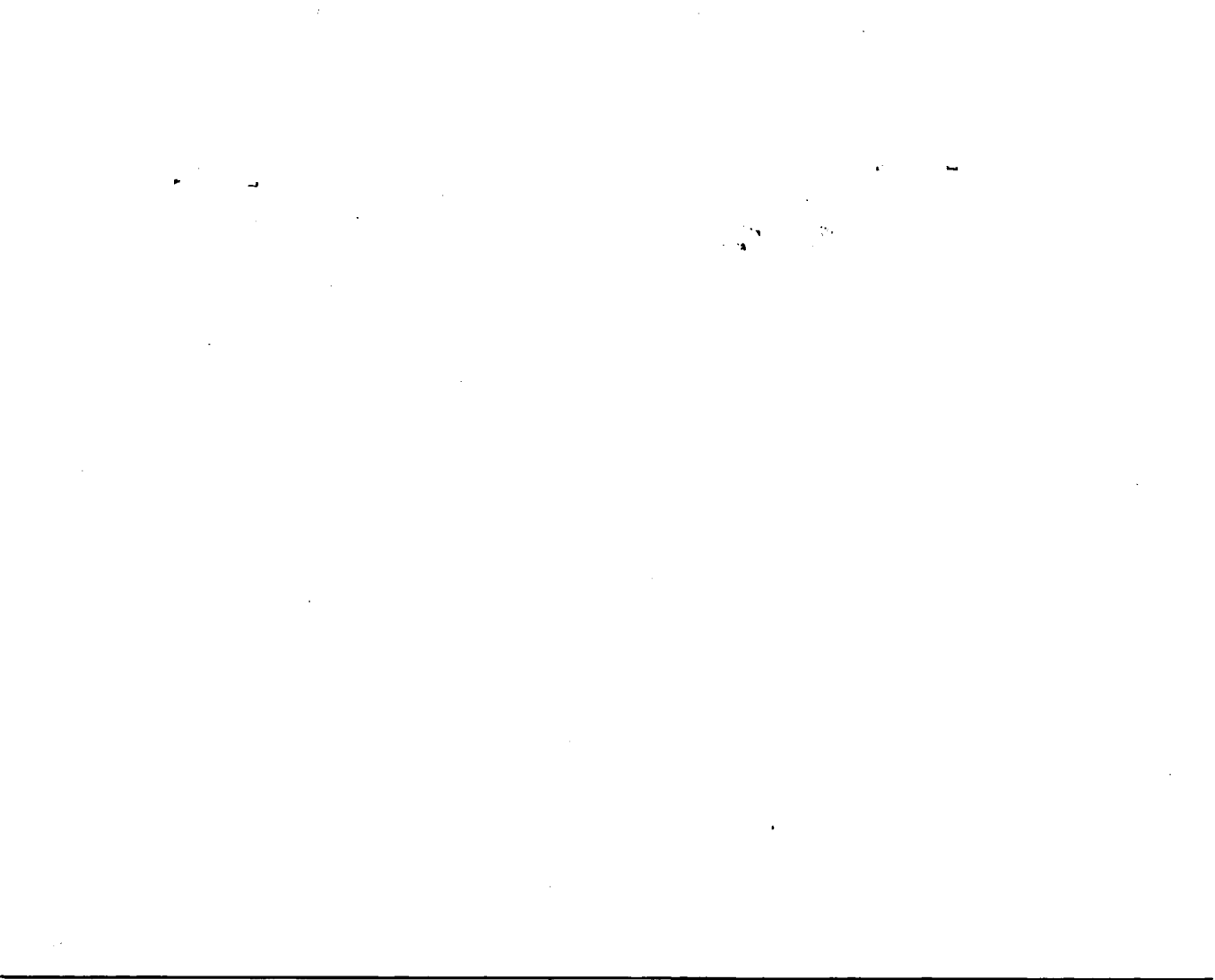
(Physician or midwife)

Address _____

Filed Sept 30 1926

Registarr.

Registarr.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. RECEIVED NOV 13 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Custer
City of ChallisRegistration District No. 108
Primary Registration District No. 2186
(No. _____ St.)State File No. 55204
Local Registrar's No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm. McGowan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH

May 28 1925
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
_____ hrs. or
_____ Yrs. _____ Mos. _____ ds. _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Arthur Wells McGowan

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Edna Rozella Niece

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Arthur McGowan Jr.
(Address) Challis, Idaho

15.

Filed Oct. 1 1926 Edna M. Kenny
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 28 1925
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 28 1925 to May 28 1925
that I last saw him alive on May 28 1925
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Drowned at 6 mo. No Cause knownContributory
(Secondary)(Signed) E. S. Hartley M. D.19. (Address) Challis, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Challis

DATE OF BURIAL

May 28 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds., Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

363-120-044-165
PLACE OF BIRTH

RECEIVED OCT 12 1906

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Washington

City of Cambridge

CERTIFICATE OF BIRTH

No. St. Registration District No. State File No. 145714

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD Infant Collins

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>—</u>	and {	Number in order of birth <u>—</u>	Legiti- mate? <u>yes</u>	Date of birth <u>8-20</u> <u>1906</u>
					(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME James Collins
RESIDENCE Cambridge-Idaho
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Stockton-Missouri
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME May Jones
RESIDENCE Cambridge-Idaho
COLOR White AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Cambridge-Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive 2:00 A M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. H. Heman

(Physician or midwife)

Address Cambridge Idaho

Filed 10-10- 1906

Registrar.

Registrar.

SEP 18 1941

day

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

844.206

006.497

Delayed

Complete

September 1925

DEPARTMENT OF COMMERCE—BUREAU OF THE CENSUS

State File No.

RECEIVED

SEP 8

1925

STANDARD CERTIFICATE OF BIRTH

Registered No.

1A

S

1. PLACE OF BIRTH—

County

Ft. Hall Reservation

State

Idaho 145905

Township

or Village

City

No.

St.

Ward

(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child

Jennie Houtz

(If child is not yet named, make supplemental report, as directed)

3. Sex of child

Female

To be answered ONLY in event of plural births.

4. Twin, triplet or other

5. Number, in order of birth

6. Legitimate?

yes

7. Date of birth

Sept. 6 1925

(Month, day, year)

8. Full name

FATHER

Herbert Eugene Houtz

9. Residence

624 W. Young St. Pocatello

(Usual place of abode)

Idaho

If nonresident, give place and State

10. Color or race

White

11. Age at last birthday

23

(Years)

12. Birthplace (city or place)

Pocatello

(State or country)

Idaho

13. Occupation

Nature of Industry

Sheep raising

14. Full maiden name

MOTHER

Effie Diggins

15. Residence

624 W. Young St. Pocatello

(Usual place of abode)

Idaho

If nonresident, give place and State

16. Color or race

Ind 3/8

17. Age at last birthday

27

(Years)

18. Birthplace (city or place)

Ft. Hall Reservation

(State or country)

19. Occupation

Nature of Industry

Housewife

20. Number of children of this mother (Taken as of time of birth of child herein certified and including this child.)

(a) Born alive and now living

2

(b) Born alive but now dead

1

(c) Stillborn

1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6 P. m. on the date above stated.

(Born alive or stillborn)

No doctor attending.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Signature

Henry R. Wheeler

Physician

(Physician or Midwife)

Given name added from a supplemental report

(Month, day, year)

Address

Ft. Hall, Idaho

Filed

19

Registrar.

WHY BIRTHS SHOULD BE REGISTERED

There is hardly a relation of life, social, legal, or economic, in which the evidence furnished by an accurate registration of births may not prove to be of the greatest value, not only to the individual but also to the public at large. It is not only an act of civilization to register birth certificates but good business, for they are frequently used in many practical ways:

- (1) As evidence to prove the age and legitimacy of heirs;
- (2) As proof of age to determine the validity of a contract entered into by an alleged minor;
- (3) As evidence to establish age and proof of citizenship and descent in order to vote;
- (4) As evidence to establish the right of admission to the professions and to many public offices;
- (5) As evidence of legal age to marry;
- (6) As evidence to prove the claims of widows and orphans under the widows' and orphans' pension law;
- (7) As evidence to determine the liability of parents for the debts of a minor;
- (8) As evidence in the administration of estates, the settlement of insurance and pensions;
- (9) As evidence to prove the irresponsibility of children under legal age for crime and misdemeanor, and various other matters in the criminal code;
- (10) As evidence in the enforcement of law relating to education and to child labor;
- (11) As evidence to determine the relations of guardians and wards;
- (12) As proof of citizenship in order to obtain a passport;
- (13) As evidence in the claim for exemption from or the right to jury and military service.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

469 103 010912

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 335022

No. 297 So Water St. Registration District No. State File No.

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD

Morgan

(Certificate of no value without full name of child)

Sex of
Child MaleTwin
Triplet
or other?} and { Number
in order
of birth
(To be answered only in event of plural births)Legiti-
mate? YesDate of birth 8 3 1925
(Month) (Day) (Year)

What bactericidal solution was used in eyes? 20% Argrol

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

Earl Morgan

FULL
MAIDEN
NAME

MOTHER

Emma LeVell Rasmussen

RESIDENCE

Idaho Falls, Idaho

RESIDENCE

Idaho Falls, Idaho.

COLOR

White

AGE AT LAST
BIRTHDAY 25
(Years)

COLOR

white

AGE AT LAST
BIRTHDAY 19
(Years)

BIRTHPLACE

American Falls

BIRTHPLACE

Mink Creek

OCCUPATION

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 10:45 A.: M.
on the date above stated.*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address Idaho Falls, Idaho.

Filed 10 10 1925

Registrar.

Registrar.

show other evidence of the fact that the latter was no sleeping physician at night, after the latter hour of 7 P.M. A witness called neither at the house nor at the office of the latter.

Exact statement of OCCURRENCE. state CAUSE OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificate.

FORM 7. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonnerville
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No. 23

BURIAL DISTRICT
(STATISTICS)

District No. 21 N 4
(STATISTICS)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 51012
Local Registrar's No. 107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Baby

6. DATE OF BIRTH

Sept 3, 1925
(Month) (Day) (Year)

7. AGE

Still Born
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Baby
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Carl Morgan

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Lovel Basmussen

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl Morgan

(Address) Idaho Falls

15. Sept 12 1925

Local Registrar W. C. Hollister

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 3, 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/3 1925 to 9/3 1925

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) W. C. Hollister M. D.

19..... (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the State..... yrs. mos. ds.

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

20. UNDERTAKER W. C. Hollister

ADDRESS Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."